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ORIGINAL LECTURES.

CLINICAL LECTURE

ON PERICARDITIS, PROBABLY THE RESULT OF TRAUMATISM; AND ON THE TREATMENT OF PLEURISY.

Delivered at the Philadelphia Hospital

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Reported by WILLIAM H. MORRISON, M.D.

GENTLEMEN,—I propose to-day to call your attention to this man, who was admitted to the hospital six days ago. The patient stated that he had been injured in a railroad-accident about seven weeks ago. He was jarred between the seats in some way, but did not notice any special inconvenience, beyond the general shaking up, until two or three weeks later, when pain in the præcordia, cough, and dyspnœa appeared, and these have continued up to the present time.

Upon admission, he complained of marked shortness of breath, a dry cough, with a severe pain in the chest, which was rather more marked over the præcordia than elsewhere, and radiated around to the left side. His temperature, which was 99° on admission, went up to 102° the same evening. Since then the temperature has ranged between 99° and 101°. On admission, the pulse was about 100 per minute, and slightly dicrotic.

Our interest, of course, centres in the diagnosis, and naturally the seat of the pain and the dyspnœa attract our attention to the chest. Percussion of the chest shows marked flatness over the region of the heart. Above the second rib there is dulness. The first clinical point to which I call attention is the recognition of the difference between dulness and flatness. By contrasting the flatness obtained over a perfectly non-resonant mass with the dulness obtained over a partially resonant area, we may be tempted to call the dulness good resonance; but by contrasting the dulness with the percussion-note heard over a normal portion of the chest, its true quality is recognized. In the left axillary region there is resonance, and also posteriorly from the top to the bottom of the chest. The right side is everywhere resonant.

Listening over the right side of the chest, I recognize an exaggerated respiratory murmur. Over the left side posteriorly a respiratory murmur is heard, which is vesicular, although feeble. If the patient take a forcible inspiration, you might call it feeble bronchial breathing, but it still has the vesicular element. It is not quite harsh enough to be properly called bronchial breathing, nor is the expiratory sound high-pitched. Auscultation during quiet breathing gives a very faint respiratory murmur, so faint, indeed, that you might infer that there was absence of respiratory murmur. Auscultation of the præcordia reveals very feeble, indistinct heart-sounds. The word "distant" is the proper one to convey the muffled character of the sounds, which are without murmur. The same muffled character of the sounds can be reproduced by placing a layer of cotton over the healthy heart. Examination of the præcordial and epigastric regions by inspection shows the existence of a pulsation; but, adding palpation to inspection, we find that the apparent pulsation in the epigastrium is merely a transmitted vibration. Examination of the præcordia by inspection shows that there is prominence of this region. Inspection of the chest shows that while the right side moves distinctly in respiration, the left is perfectly quiet.

What shall be our diagnosis from the signs which have been elicited? Evidently some one had made the diagnosis of pneumonia or pleurisy before he was admitted to the hospital, for his back bore the marks of cups. The question of pneumonia can, I think, be readily dismissed. In the first place, there is no bronchial breathing at any part of the chest. In the second place, the only area of dulness is in front over the præcordial region. If this dulness had been on the right side, we might have attributed it to consolidation of the middle lobe of the right lung; but, as the left lung has no middle lobe, this idea can be dismissed. The flatness is over the præcordia, and not over the lung proper. Again, it is impossible to suppose that the man has had pneumonia for four weeks and not present any more positive signs to-day.

The question in regard to pleurisy is

not so readily disposed of. In favor of pleurisy we have the feeble respiratory murmur and the diminished movement of the left side, while, on the other hand, there is exaggerated respiratory movement, exaggerated respiratory murmur, and increased resonance of the right side. All these signs, of course, indicate that the left lung is disabled. Having excluded consolidation of the lung, it would seem probable that pleurisy exists. At the same time there is one strong point against the idea of pleural effusion, and that is the resonance on percussion over the left chest. This excludes pleurisy as a general condition, but it does not exclude a localized pleural effusion. Flatness on percussion is almost always due to the presence of fluid. I think that it may be said that the sound given by pulmonary consolidation is always dull, while the sound given by a collection of fluid is always flat. We, however, dismiss the idea of a sacculated pleural effusion, partly by exclusion, and partly by means of another line of reasoning, to which I shall refer in a few minutes. A localized pleural effusion in the region of the præcordia would be very unusual. Occasionally a localized effusion occurs at the apex, but even this is rare. I recall one case, exhibited last year at the University Hospital clinic, in which a localized empyema occupied the space between the third rib and the clavicle on the right side. Such effusions usually occur posteriorly, and not anteriorly. Therefore, if we have any more satisfactory explanation of these physical signs, we have good grounds for excluding sacculated pleurisy.

The area of flatness and the muffled heart-sounds point to some lesion of the pericardium. We may have fibrinous inflammation of the pericardium, in which both the heart and the pericardium are covered with fibrinous exudation. We may also have a serous inflammation of the pericardium, in which serous fluid is thrown out. These conditions are analogous to fibrinous and serous inflammation of the pleura. When the pericardial process is developed slowly, it is more common to have the fibrinous form of the exudation in excess. The history of the case and the physical signs would point to such a condition. Pericarditis, however, never develops spontaneously, like pleurisy. In a large proportion of cases, probably two out of every three, it develops in consequence of rheumatism. I have carefully investigated the history of this patient, but can find no evidence of rheumatism. This is a great point against the diagnosis of pericarditis. After rheumatism, the largest number of cases are associated with chronic Bright's disease. There is no Bright's disease in this case, so far as can be made out from the examination of the urine and of the general condition. The next most frequent cause of pericarditis is some disease of the lungs or pleura, more particularly the latter. We have already said that there is no reasonable ground to believe in the existence of pleurisy. Some cases of pericarditis are produced by tubercle, and a few cases by cancer, but these conditions are readily excluded in this case. Then we have sometimes abscess of the liver perforating the chest and producing pericarditis. These are all indirect causes. We have said that the patient has no rheumatism, no Bright's disease, no affection of the pleura or lungs; he has no tubercular disease nor malignant disease; there is no abscess of the liver, and no peritonitis. Having excluded these causes of pericarditis, how is the condition, if it does exist, to be explained?

I attribute it to the injury, for direct local injury will account for a small fraction of the cases of pericarditis not accounted for by the causes already enumerated. If this were a case of ordinary pericarditis, could it develop in this slow, latent way?

One reason for bringing this case before you is because this disease will be frequently overlooked unless the physical signs are carefully considered. This is an affection which is chiefly recognized by the physical signs. The symptoms are, as a rule, indefinite and not sufficient to allow any one to make a diagnosis without a careful physical examination. This man is suffering from dyspnœa, but this is not so severe as to make one suspect that the cardiac sac was the seat of inflammation. Occasionally there is violent dyspnœa and the delirium of which you read in the text-books, but usually the cases of pericarditis seen in actual practice closely resemble the one before you.

In this case, if we conclude that our patient is suffering from pericarditis, we must explain the occurrence of the pul-

monary symptoms. This can be easily understood if the anatomy of this region is recalled. The pericardium rests on the large bronchial tubes, and if effusion occur into the pericardial sac pressure is exerted on the bronchial tubes of the left side and air is prevented from entering the left lung. I am disposed to account for the feeble breathing and the absent respiratory movements by the pressure of the pericardial sac—enlarged as it is by the inflammatory process—upon the bronchial tubes, and I am inclined to regard the dulness which is present at the apex of the left chest anteriorly as due to the partially-inflated lung, just as we explain the dulness in the hypostatic congestion of typhoid fever. All the respiratory symptoms may be ascribed to the pressure of the pericardial sac upon the bronchial tubes. The heart itself is probably drawn back into the pericardial sac, and this apparent pulsation in the epigastrium is nothing but a tremor transmitted from the heart. I think that the position of the heart, when there is pericardial effusion, is often misapprehended. In one case, and the only case in which I have tapped the pericardial sac, a distinct pulsation was felt in the position of the apex, and I introduced the trocar with fear and trembling lest I should strike the heart. Examining as well as I could with the canula in the pericardial sac, I found that the heart was crowded over somewhat to the right and into the upper part of the sac. The pulsation which I had felt had been transmitted through a layer of fluid. In this case you recollect that we made the diagnosis of fibrinous, not serous, pericarditis, and the effusion, though extensive, is not as large as frequently observed.

What shall be done for the patient under these circumstances? The treatment of pericarditis depends altogether upon its cause. If in a case of articular rheumatism the symptoms of pericarditis make their appearance, you will simply continue the treatment of the rheumatism. If that is the alkaline treatment, you simply push the alkaline remedies. As you are aware, there are two plans of treating rheumatism,—the method with large doses of alkalies and the method with the salicylates of sodium or ammonium. I might expand this idea of the treatment of rheumatic pericarditis so far as to say that the salicylates are useful in rheumatism to control two symptoms,—the pain and high temperature. Often after the administration of this remedy the temperature rapidly falls and the pain disappears, and rapid convalescence may follow. At other times, although the pain and fever are lessened, the inflammation of the joints persists. This is because there still remains in the blood a certain amount of nitrogenous material, which is one of the causes of rheumatism, and which should be eliminated. As these products of retrograde tissue-waste are only eliminated in combination with alkalies, as urates of sodium and potassium, these alkalies should be administered. My own plan is to always use the alkalies in addition to the salicylate of sodium until the urine becomes alkaline. When this occurs I diminish the amount of alkali, but still continue it in sufficient quantity to keep the urine alkaline.

When pericarditis occurs in the course of Bright's disease, treatment will not be of much service, but the usual regimen for Bright's disease will be proper.

As I believe that this is merely a simple inflammation of the serous sac, I shall treat it as we ordinarily do inflammation of a serous membrane. I shall apply blisters, and use acetate and iodide of potassium internally. This is not the alkaline treatment, for I do not push these remedies in large doses. We now are administering ten grains of acetate of potassium with five grains of the iodide four times a day. Small blisters are applied over the præcordia. The action of the heart has been supported by small doses of digitalis. On admission, the pulse was dicrotic, and the action of the heart embarrassed and diminished by the exudation around the organ. The indication was therefore to support the action of the heart while trying to remove the inflammatory exudate. We have given ten drops of the tincture of digitalis three times a day, and for the first day or two alcoholic stimulus was also used, but this has been discontinued.

I wish to make a few remarks on one symptom, to which I have intentionally refrained from referring until the present time. This symptom is friction-râle, which is very characteristic of pericarditis. So far as this case is concerned, this sign has been of no value in the diagnosis, because the case came under observation

after the friction-sounds had disappeared. When, however, friction-sounds are present, how will you differentiate them from a murmur produced within the heart? By the following points. A pericardial friction-sound is superficial; it is a grazing, to-and-fro sound. Sometimes pericardial râle cannot be distinguished from an endocardial murmur by these signs. The great point is that an endocardial murmur will be transmitted in the direction of the blood-current by which it is produced. In other words, if an endocardial murmur is produced in the aortic region, it will be transmitted into the carotid arteries or along the course of the aorta. If you have a mitral regurgitant murmur, it will be transmitted in the direction of the blood-current,—viz., back into the lung through the left auriculo-ventricular opening,—and may therefore be heard in the axilla. A pericardial friction-sound is, on the other hand, heard only at the position where it is produced, or in that immediate vicinity, and a pericardial friction-sound will change its position. If some of the exuded lymph is polished down by the action of the heart, the friction-sound will disappear from that position and will be heard at another point, at which new roughnesses form. An endocardial murmur does not change its position, and is constantly heard at the valvular points. The friction-sound is synchronous with the movement rather than the sounds of the heart. Commonly, it is heard over the base of the heart or near the orifices of the vessels. Change of posture may induce an increase of murmur, rendering a murmur which is faint in the vertical quite distinct in the recumbent. Finally, the alterations common to the walls of the heart in endocardial disease are absent.

THE TREATMENT OF PLEURISY.

I bring before you another case, which you have seen on a previous occasion. The patient came into the hospital about six weeks ago. He then had a large pleural effusion filling the left chest from the clavicle to the base. This effusion had taken place slowly, requiring at least ten days to reach its height, so that the patient did not suffer markedly from dyspnœa.

I have brought the case before you in order to show you two things: first, the progress of the case under treatment; secondly, to demonstrate the physical signs of pleural effusion in the stage of absorption. The patient was treated by jaborandi sweatings. The treatment has been a teaspoonful of the fluid extract of jaborandi every other day for two weeks, and then about three times a week to the present time; so that he has been under this treatment for four or five weeks. Together with this he has received ten grains of iodide of potassium three times a day. Within the last two weeks we have practised inunctions of mercurial ointment, applying it first to one axilla, then to the opposite axilla, and then to the groins. I have found that when a pleural effusion reaches a certain point absorption is very slow, and I believe that the careful use of mercurial ointment will quicken absorption in this stage.

I shall now percuss the chest, in order that you may see the improvement. While sitting up there is perfect resonance anteriorly. Over the back the percussion-note is almost flat. As you can see, small blisters, about the size of a dollar, have been applied. Often there will be, during the absorption of pleural effusion, a tympanitic resonance over the anterior portion of the chest. When these physical signs are limited to a small area near the apex of a lung, they may suggest the presence of a cavity. The mistake may be avoided by noting the absence of the usual auscultatory signs of such a condition.

The only further point which time permits me to observe is that the decubitus of the patient has a great deal to do with the shape of the effusion in the chest. This patient's chest still has considerable fluid in it. There is complete absence of respiratory murmur on the left side posteriorly. The reason that the remainder of the exudate occupies this position is because the recumbent posture has been maintained through the attack. I have instructed him to sit up more or less, and if he do this the absorption of the fluid will, I think, be materially quickened.

OXALURIA.—Dr. Charles N. Durselen, of Chicago, recommends the employment of biphosphate of sodium and nitro-muriatic acid in the treatment of oxaluria, the latter agent being especially applicable to cases connected with dyspepsia or disordered state of the liver, and in hypochondriacal cases. In simple cases, especially if accompanied by anæmia or with costiveness, better results will be obtained from the former remedy.

ORIGINAL COMMUNICATIONS.

ON RAPID DILATATION OF THE UTERINE CANAL.

BY WILLIAM GOODELL, M.D.

(Remarks made at the Obstetrical Society of Philadelphia, October 2, 1884.)

FOR many years I enlarged or straightened the uterine canal, according to the requirements of the case, either by tents or by Sims's operation, and preferably by the former. Having had several serious warnings, in the shape of inflammation following these operations, I began to perform them with fear and trembling. Yet nothing very untoward happened until the year 1878, when two grievous mishaps befell me.

A charming young lady, the centre of a large circle of admiring friends, came from a neighboring State to consult me about a dysmenorrhœa which grew worse and worse every year. The cervix was so bent forward, and the stenosis of its canal, *per se* as well as by angulation, was so marked, that I unhesitatingly performed Sims's operation. Within a few days septicæmia set in, soon the parotid glands swelled up, and on the ninth day she died. True it is that at the same time two piles also were tied; but this latter operation I had performed so many times with impunity that I was, and am still, disposed to attribute the blood-poisoning to trau matism of the cervix, and not to that of the rectum.

Hardly had I time to recover from this bitter blow, when a case of exhausting menorrhagia fell into my hands. The lady was the young bride of a husband well advanced in life, who doted on her as only old men dote on much younger wives. I dilated the cervical canal with tents and curetted many vegetations from the endometrium. A furious peritonitis set in, and in less than three days this young wife lay dead, and the husband was frantic with grief.

The anguish which I felt at the death of these two ladies, and the heart-rending scenes which I witnessed at their bedside, —scenes which I cannot now recall without emotion,—urged me to try any remedy that gave promise of efficiency combined with greater safety. In the search for a substitute I tried rapid dilatation, which Ellinger and others had proposed, and since that year—that *annus iræ*—I have not once performed Sims's operation for dysmenorrhœa, and I have so narrowed the field for the use of tents that I now very rarely resort to them. In short, rapid dilatation has proved, in my hands, so safe and so efficient an operation that I wish to urge its claims before this Society.

The instruments which I would recommend are two Ellinger dilators of different sizes. These are the best, on account of the parallel action of their blades. The smaller of these dilators has slender blades, and it pilots the way for the other, which is more powerful and with blades that do not feather. I have had the beak of this dilator changed from an obtuse angle to a slight curve, so that it can be reversed within the womb. The lighter instrument needs only a ratchet in the handles, but the stronger one should have a screw with which to bring the handles together. Lest the beak should hit the fundus uteri and seriously injure it when the instrument is opened, the blades are made no longer than two inches, and are armed with a shoulder which prevents further penetration. The larger instrument opens to an outside width of one and a half inches, and it has a graduated arc in the handles by which the divergence of the blades can be read off. The instruments which I now exhibit to you, and which I can recommend highly, have been made under my supervision by Messrs. J. H. Gemrig & Son, of this city.

In a case of dysmenorrhœa or of sterility from flexion or from stenosis, my mode of performing the operation of rapid dilatation is as follows. The patient is thoroughly anæsthetized, and a suppository containing one grain of the aqueous extract of opium is slipped into the rectum. She is then placed on her back and drawn to the edge of the bed, the knees being supported by her nurse. The light must be good, so that the operator may clearly see what he is about. By the aid of a strong tenaculum, applied through my bivalve speculum, the cervix is steadied and the smaller dilator is introduced as far as it will go. Upon gently stretching open that portion of the canal which it occupies, the stricture above so yields that when the instrument is closed it can be made to pass up higher. Thus, by repetitions of this manœuvre, little by little, in a few minutes' time a cervical canal is

tunnelled out which before could not admit the finest probe. Should the os externum be a mere pin-hole or be too small to admit the beak of the dilator, it is enlarged by the closed blades of a straight pair of scissors, which are introduced with a boring motion. As soon as the cavity of the womb is gained, the handles are brought together. The small dilator being now withdrawn, the larger one is introduced, and the handles are then slowly screwed together. If the flexion be very marked, this instrument, after being withdrawn, should be reintroduced with its curve reversed to that of the flexion, and the final dilatation then made. But in doing this the operator must take good care not to rotate the womb on its axis, and not to mistake the twist for a reversal of flexion. The ether is now withheld and the dilator kept *in situ* until the patient begins to flinch, when the instrument is closed and removed. A few drops of blood trickle out of the os. Occasionally a slight flow of blood will last for several days after the operation, simulating the menstrual flux. Often this flux is precipitated, or renewed, if the operation follows or precedes it too soon. The best time for dilatation is therefore midway between two monthly periods.

When compared with the cutting operation, this one looks like rough usage; yet the woman rarely needs more than two or three suppositories, and complains merely of soreness for one or two days. To forestall any tendency to metritis, she is kept in bed until all tenderness has disappeared. Pain is met by rectal suppositories of opium and by large poultices laid over the abdomen. I have seen slight pelvic disturbance arise from this operation, but it has always been readily controlled, and has not given alarm.

In the great majority of cases I dilate the canal not to the fullest capacity of the instrument, but to one and a quarter inches. Sometimes in an infantile cervix, which does not readily yield and might give way, the handles are not screwed down more than three-quarters of an inch or an inch. Tearing of the cervix has happened in two of my cases, from the slipping out of the instrument. In one, that of a virgin, the cervix was split halfway down to the vaginal junction. The other case was that of a multipara, whose uterine canal had been nearly closed up by applications of silver nitrate made by her physician with the view of curing what he supposed was an "ulceration of the os," but which was a bilateral laceration. The tissues, rendered cicatricial and brittle by the caustic, were torn by the dilator for about half an inch on the right side also. Here the hemorrhage was free enough to need styptic applications and a tampon. I could have stopped it by wire sutures, but this was not done, as it would have defeated the object of the operation.

For slight dilatations, such as for the office treatment of anteflexions and of stenosis, or for the introduction of the curette, or of the applicator armed with cotton, the more delicate instrument is quite strong enough, and an anæsthetic is not needed. Sometimes in a very sharply-anteflexed womb the dilator cannot be made to pass the os internum. This difficulty is overcome by first passing in a surgeon's probe, and then, along it as a guide, the dilator.

After a forcible dilatation under ether, the cervical canal rarely returns to its previously angular or contracted condition. Since lateral extension of elastic bodies antagonizes their length, the cervix shortens and widens, and the plasma provisionally thrown out by the submucous lesions sustained by the dilated part serves still further to thicken and stiffen its tissues. In other words, the stem-like neck of the pear-shaped womb is shortened, widened, strengthened, and straightened. Hence, for straightening out anteflexed or congenitally-retroflexed wombs, and for dilating and shortening the canal in cases of sterility or dysmenorrhœa arising from stenosis or from a conical cervix, the dilator will be found a most efficient instrument. In its results it is not infallible; I have twice been obliged to repeat the operation, and would like to have done so in several other cases had the women permitted it. In a very few instances I have been forced, as a final resort, to nick a pin-hole os externum; but I had not then learned how far I could safely stretch open the uterine canal, and the operation of dilatation was not so efficiently performed by me as it is now through a larger and riper experience.

But it is not to cases of dysmenorrhœa that I limit the operation of rapid dilatation. As stated before, I use it to stretch open the canal for the admission of the

curette and of sponge-tents, or for the purpose of making applications to the uterine cavity. In cases needing the irrigation of the uterine cavity I first dilate the canal with this instrument and introduce the nozzle of the syringe between the separated blades. This gives a free avenue for the escape of the liquid, and robs of its dangers this form of intra-uterine medication. I also resort to the dilator in order to explore the womb with the finger. For instance, in any given case of menorrhagia in which a polypus or some other uterine growth is suspected, instead of using tents, I put the woman under an anæsthetic, and, after the rapid dilatation of the cervical canal to the utmost capacity of the instrument,—viz., one and a half inches,—am enabled to pass my finger up to the fundus. This is accomplished either by drawing down and steadying the womb by a volsella forceps, or in thin subjects by forcing the womb down upon the finger through supra-pubic pressure on its fundus. In this way I have, over and over again, at one sitting discovered a uterine growth, twisted it off, and removed it. Usually in these cases I experience more difficulty in removing the polypus or other growth through the small canal than in twisting it off from its uterine attachment. It often has to be wire-drawn before it can be removed, and sometimes the os uteri has needed a few nicks. Usually when the menorrhagia is free the cervical tissue is so lax that there is no difficulty in the introduction of the index-finger up to the fundus, but sometimes only its tip can be made to pass the os internum. Yet even this limited degree of penetration is commonly quite enough to decide the presence of an inside growth. If it be not enough, I invariably search for a growth with a small pair of fenestrated forceps, and I have repeatedly seized and removed one the existence of which was merely suspected. After such operations the uterine cavity is thoroughly washed out with a solution of carbolic acid or of potassium permanganate.

I am sorry to say that I have not kept full records of all my cases of rapid dilatation. For instance, I have never recorded those office cases of dilatation in which ether was not given. Nor has any note been made of cases in which dilatation was performed under ether for curetting, for digital exploration of the endometrium, or for the removal of uterine growths. I have tabulated merely cases of dysmenorrhœa in single or in married women. In the married, with but three exceptions, which will be noted, painful menstruation was associated with sterility.

Including all the cases of dilatation performed under ether, I must have had over three hundred. I have limited myself to these cases because the use of an anæsthetic implies full dilatation,—one in which serious injury, if ever, would most likely be sustained. Yet there has not been a death, or a case even of serious inflammation, in my practice, and the results have been most satisfactory,—far more so than when the cutting operation was performed by me. The following are the statistics of my cases of dysmenorrhœa: single, 80; married, 88. Total, 168.

Of the unmarried, eighteen were unheard from after the operation, leaving sixty-two from which any data could be obtained. Of these, thirty-eight were cured, seventeen more or less improved, and seven not improved at all. Of these seven that were not benefited by the operation, five subsequently had their ovaries removed,—one of them by another physician and four by myself: of the latter, one died. In each one the ovaries had become so altered by cystic or by interstitial degeneration as to make the dysmenorrhœa otherwise incurable. Of the seventeen improved, there was one on whom öophorectomy was also performed; for, although the dysmenorrhœa was greatly relieved by dilatation, ovarian insanity and menorrhagia were not. The operation was a successful one, and my patient was not only cured of her hemorrhages, but she regained her reason. Out of these cases, the majority, although not wholly cured, were greatly improved. For example, one of them was formerly bedridden during the whole period of her menstrual flux, and had then to take large doses of morphia. She also suffered at those times from hæmatemesis and epistaxis. Since the operation she experiences pain for merely two hours, needs no anodyne, and has lost her ectopic hemorrhages. Her gain in health and flesh has been great. Another one, who was wholly crippled by her sufferings and made nervous by the dread of them, is now a busy nurse. For one hour at every period she

suffers a great deal; but she is too much afraid of taking ether to have a second dilatation performed.

Of those cured, two had Sims's operation performed previously without benefit, and were afterwards dilated; two were dilated twice before a cure could be brought about. The history of several cases merits more than a mere allusion. The sufferings of one of my patients at every monthly period had always been great, but while she was at a boarding-school they grew so intense as to cause furious delirium at those times. This finally developed into permanent insanity, with suicidal impulses. While in this condition she was placed in my hands. After rapid dilatation of the cervical canal, the dysmenorrhœa wholly disappeared. The exemption from pain toned down some of her more extravagant delusions, but she did not wholly regain her reason until a few months afterwards. She is now free from all menstrual pain, and in the complete possession of her mental faculties.

A Hebrew lady, whose health had suffered from dreadful dysmenorrhœa, was so much improved at one sitting that her physician and friends were amazed. Not long afterwards the doctor asked me to perform this operation upon another one of his patients, who was, if anything, worse. Her sufferings were so intense that he wrote, "I fear that another period might kill her," and urged an immediate operation. The cervix in this case was conical and very dense. Fearing a tearing of the parts, I screwed the instrument slowly up to one and a quarter inches, and kept up this amount of dilatation for some twenty minutes. The cervix sustained no injury. The canal has since remained patulous, and she is free from all menstrual pain.

Of the married, fifty-three were heard from. Of these, thirty-nine were cured, ten improved, and four unimproved. Out of these fifty-three cases, nine were not in a condition to conceive, three of them from fibroid tumors, two from destructive applications of nitrate of silver to a lacerated cervix, three from being over forty-one years of age, and one from being a widow. This leaves but forty-four capable of conception, and of these, eight, or a little over eighteen per cent., became pregnant. But the ratio is in fact larger, for several of my patients, fearing pregnancy, employed preventive measures after the operation. Then, again, I believe that others, who consulted me merely for painful menstruation, have not reported their subsequent pregnancies. For instance, two months ago I learned through the merest accident that the wife of a clergyman, whose cervical canal I dilated six years ago, has since been making up for lost time by giving birth to twins within a year after the operation, and later to several other children. She had been married eight years before she came to me, and had had her cervical canal dilated by tents and slit up with Peaslee's metrotome by a skilful surgeon. I have also had several cases of pregnancy following office-dilatations of the uterine canal, in which ether was not given, and consequently the lumen of the canal was not much enlarged. But such slight operations were not deemed worthy of record, and they therefore have no statistical value.

CLINICAL ASPECT OF SOME PERIPHERAL PALSIES.

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IN glancing over the neurological literature of some of our recent and standard works on the practice of medicine, I find only a brief mention or an entire omission of some of the commoner forms of peripheral palsies, leading one to infer that they rarely occur or do not happen at all. Even some of those omitted I find to be very common, so that a short account of their clinical aspect will not be out of place. In degree of frequency the different parts of the body are affected in the following order: first the nerves of the face and neck, then the upper extremities, and lastly the lower extremities. I shall only mention some of those of the extremities.

Case I. Paralysis of Musculo-Spiral Nerve.—C. C., æt. 40 years, a book-canvasser, intemperate. Two weeks ago, after drinking heavily, he fell asleep with his arm resting over the back of a chair. In two hours he awakened, experienced nothing wrong, went home, and slept well that night. The next morning he noticed a numbness in the back of the forearm, and a tingling and numbness in the hand, extending along the dorsal surface of the fingers, with an inability to lift the hand. In a few days the tingling disappeared,

the loss of power in hand and numbness of dorsal aspect of thumb remaining.

Present Condition.—Has marked wrist-drop. By great effort he can lift his hand midway between flexion and extension. When the wrist is supported he can extend the two distal phalanges and adduct and abduct the fingers by the aid of the lumbricales and interossei. Supination and pronation are perfectly performed. He describes a numbness extending over the posterior interosseous space of forearm and dorsal aspect of thumb. Pressure over this space elicits tenderness. He can extend the last phalanx of thumb. When the wrist is supported he has normal grasp-power, and when unsupported he can grasp firmly only small objects. Flexion and extension of forearm are normal. No loss of sensation. Surface-temperature of extensor side of right (sound) forearm, 95°; left, 94°. After faradizing paralyzed muscles, surface-temperature, right 95°, left 95½°. There is slightly-diminished faradic contractility.

He was treated with counter-irritation over the course of the posterior interosseous nerve, and the labile descending galvanic current was applied to the nerve and muscles. He made a slow recovery.

This is a very common form of palsy, and presents many different degrees. It bears a great resemblance to the wrist-drop of lead-palsy, but is easily differentiated. The latter is generally bilateral, is usually accompanied with or preceded by symptoms of plumbism. Another differential point given by authors is that in paralysis of the musculo-spiral nerve you have loss of the power of supination, whereas in the paralysis of plumbism the supinator muscles are never involved. In reviewing my cases of musculo-spiral palsy, I find that this distinguishing point must be received with some allowance, as in all my cases of pure nerve-paralysis, even where the loss of power of extensor muscles was complete, supination was nearly normally performed.

When the nerve is injured high up, the triceps muscle is paralyzed. Then you may have, as in one case of mine (where the nerve was injured during the birth of the child), loss of power to extend the forearm and of supination of the hand. Erichsen, in his book on Concussion of the Spine, reports cases of paralysis of this nerve in fracture of the shaft, lower condyle, and lower epiphysis of humerus, in which the supinator muscles were not at all or but slightly impaired. Dr. S. W. Mitchell, in his "Injuries of Nerves," reports a case of injury to this nerve by the fragment of a shell, in which the extensor muscles of the thumb and fingers were completely paralyzed, whilst the actions of the supinators longus and brevis were but slightly impaired. In the same work he reports a case of injury to the median and ulnar nerves, in which the supinator longus muscle was paretic. The remaining muscles supplied by the musculo-spiral nerve were normal. There are various causes of paralysis of this nerve, the most fruitful being compression in intemperate men, where the arm is in some malposition whilst the muscular system is thoroughly relaxed by the intoxication.

Case II. Compression of the Median Nerve.—J. J., æt. 39 years, tailor. Had syphilis some five years ago. Is intemperate. July 5 he was drinking heavily, and fell asleep on his left arm. The next morning he noticed numbness in the left thumb, index, and middle fingers. He worked till July 11, when the numbness, and especially the weakness in the digits, mentioned, compelled him to cease. He has now, ten days after the accident, numbness of ends and palmar surfaces of thumb, index, middle and outer half of ring fingers, and of radial half of palm. There was also a space of numbness over the dorsal surfaces of the thumb and index-finger, involving in some way the radial distribution. Over the anæsthetic parts described he could not feel two points of the æsthesiometer ever so far apart. Compression over the course of the nerve elicited no tenderness. He could feebly flex, abduct, and adduct all the fingers, but the muscles having these functions were decidedly paretic, as the dynamometer registered 60 less as compared with the healthy side. The electrical condition was hyperexcitability to the galvanic current and slightly impaired faradic contractility. He was treated with rest to the parts, continuous current and counter-irritation over the course of the nerve. After four weeks of treatment he was markedly improved.

It is difficult to account for the anæsthetic surface on the dorsal aspect of the thumb, except by an interchange of sensory fibres between the median and radial nerves, or, as quoted by Alen,* W. O. Schnitzer infers from clinical data that the dorsal surfaces of some parts of the thumb, second, and third fingers have their cutaneous supply from the median nerve.

The median nerve, to the exclusion of

* Lähmungen der Armnerven, etc. Berlin, 1876. Abstract in Centralblatt für Med. Wissen., 1878, xvi. 190.

other nerves, is not so often affected with paralysis as the musculo-spiral; for it to be paralyzed in conjunction with other nerves coming from the brachial plexus is much more common. Generally the median and ulnar suffer together. Not uncommon causes of injury to this nerve are ill-adapted crutches, awkward venesections, rheumatism, etc.

Case III. Paresis of Ulnar Nerve.—K., æt. 80 years, watchmaker, a very healthy and vigorous old man. Has always worked with his right elbow resting on a table. In November he began to have symptoms of vesical catarrh, which undermined his health considerably. About this time he noticed a tingling and numbness in the distal ends of the little and ring fingers, and later his power of grasp became impaired. He was unable to hold his tools firmly in the hand. When I first saw him he had loss of sensation in palmar surface of little and inner half of ring finger, and in ulnar third of palm. The anæsthesia of the dorsal surface of hand was not sufficiently distinct to enable me to map out the ulnar distribution. His grasp was weak, the whole hand being affected, but the little finger and adduction of thumb to a greater degree. Pressure over the ulnar nerve elicited tenderness and a tingling in the ends of the inner two fingers. He abstained from work on account of the bladder-affection, to which I gave my whole attention. After this was removed and his general health had improved, his hand-weakness became prominent, but was soon relieved by counter-irritation, galvanism, and iodide of potassium internally.

This man had been leaning on his ulnar nerve probably for half a century, has never had a day's sickness in his life, and only when he is run down by a bladder-trouble did this paralysis manifest itself. Why it should take place just at this time can be explained in one of two ways. The previous ill health the man had been laboring under reduced the amount of areolar tissue, thus diminishing the natural protection and exposing the nerve to pressure, or his run-down system predisposed the nerve to disturbance from slight causes. Another fruitful cause is injury to the elbow-joint, as in a case of mine where there was a dislocation of the fore-arm backwards; after the reduction, the joint swelled, tingling and a drawing sensation appeared on the ulnar side of the hand and palm, followed by paralysis and atrophy of the muscles supplied by this nerve, which has not passed away to this day, four months after the accident. When paralysis of the ulnar nerve is complete, a peculiar deformity develops,—claw-hand,—which is due to the unopposed action of the antagonistic muscles of the interossei.

Case IV. Paralysis of the Peroneal Nerve from a Novel Way of Compression.—A. B., aged 30 years, pocketbook-maker. August 25, being out of work, he paved his yard with bricks, which required continual stooping. The third day he felt lame and sore from the extreme flexion of the knees, the left being the worst. He had great difficulty in rising from the stooping posture. A few days' rest restored the right leg entirely, the left continuing weak. He had at the time no fever, no muscular twitching, and no pain. Otherwise he was in the best of health.

Present Condition.—In walking, his left foot falls in extreme extension, and he lifts the foot by flexing the thigh, in order to prevent the toes striking the floor. He cannot flex, abduct, or adduct the foot, nor extend the toes,—movements produced by muscles supplied by the peroneal nerve. When any of these acts were attempted, there was involuntary extension of the foot. Sensation was lost on the outer aspect of leg, distinctly mapping out the sensory distribution of the peroneal nerve. Plantar reflex impaired, patellar reflex normal. Pressure over the nerve produced no pain. Electrical condition: both nerve and muscle show diminished faradic contractility. In the nerve the galvanic current gave Ca cc > An cc. The muscle, Ca cc = An cc. Surface-temperature (over anterior tibial group of muscles): left, 95°; right (sound) side, 97°.

He was treated by a labile descending galvanic current over nerve and muscles, rest, and potassium iodide internally. He did not improve after being under treatment three weeks, and left.

This paralysis was evidently due to compression of the nerve by the prolonged and extreme flexion of the knee-joint.

In support of my belief that this was the cause, I have the following experiment. Place an index-finger horizontally in each lateral half of the popliteal space; then stoop, bringing the entire weight of the body on the extremely flexed knee, and in trying to pull out the fingers you will find the outer fingers grasped more firmly: thus demonstrating that the outer lateral surfaces are brought in closer apposition than the inner.

Given a case of localized paralysis, by what points are we to distinguish whether it be central or peripheral?

PERIPHERAL PARALYSIS.	CENTRAL PARALYSIS.
Generally unilateral, and situated in the distribution of an individual nerve.	Usually bilateral when spinal, hemiplegic when cerebral.
Muscular atrophy.	No atrophy, unless multipolar ganglion-cells of anterior horns of gray matter are involved, and in those cases muscles are paralyzed which have different nervous supply, lying on opposite sides of the limb.
Paralysis first, and atrophy follows.	In progressive muscular atrophy there is also atrophy, but paralysis keeps pace with the atrophy.
Disturbances of sensation.	Seldom marked disturbance of sensation.
If of long standing, electro-muscular contractility absent, or the reactions of degeneration may be found.	Electro-muscular contractility only slightly impaired, except in infantile and adult spinal paralysis, where there is either lost electrical excitability or the reactions of degeneration; then the history of the case is a guide.

Paralysis due to compression or inflammation of the nerve presents important differences. In inflammation we have pain or elicit pain on pressure, which is seldom the case in paralysis due to pressure; and, if decided pain is found, we may conclude that there is more or less inflammation. Peripheral palsies are due to various forms of pressure, such as inflammatory products, cicatrices, callus, tumors, passage of fœtal head through pelvis, fæcal accumulations, muscular spasm, obstetric forceps, malposition of the extremities, and ill-fitting crutches. Where the pressure is temporary, at first both motion and sensation are affected, but the motor palsy lasts longer and is more profound.

The pathology of peripheral palsies has not been thoroughly investigated. S. W. Mitchell, after some experiments on nerves by compression where post-mortem examinations were made, states "that in all cases were noted some evidences of congestion, but the chief lesion lay in a very extensive disturbance of the contents of the nerve-tubes."

Prognosis is generally favorable. Where the cause has been only temporary and the paralysis partial or complete, it will require six to eight weeks to effect a cure. In cases of paralysis with atrophy, the prognosis is not so favorable as to a complete cure, but the palsy may be improved. The electrical condition of the muscles will give the best clue to base a prognosis upon. If there is no diminished electro-muscular excitability to either current, then the case is favorable. If the muscles do not respond to the faradic current, but to the interrupted galvanic, giving An cc > Ca cc, there is hope, after a long time of treatment, of restoring the parts to usefulness. When all electrical response is absent, the case is probably beyond a cure; but even then the interrupted galvanic current should be tried.

Treatment.—If the palsy be due to an acute or chronic neuritis, rest, soothing applications, and the ordinary antiphlogistic course should be ordered. In chronic neuritis nothing will yield more charming results than blisters over the course of the nerve. Iodide of potassium internally also acts well. Electricity should not be used in acute neuritis. Should the muscles respond to the faradic current, gently faradize three times weekly. If the muscles do not respond to this current, use the interrupted galvanic, placing that pole on the motor point of the muscle which obtains the minimum of contraction from the smallest number of cells. In compression-paralysis, if you find a spot of tenderness in the course of the nerve, use a blister. Otherwise nothing much can be done but to wait, keep up the tone of the muscles with electricity, and apply a constant descending current over the course of the nerve, in hopes of producing some healthy change in the nerve-structure itself.

FOREIGN BODY IN THE EYE CAUSING SYMPATHETIC OPHTHALMIA.

Read before the Philadelphia County Medical Society, September 17, 1884,

BY M. LANDESBERG, M.D.

I HAVE the honor to exhibit to you, Mr. President, to-night, one of the most interesting cases I have ever had the good luck to meet with in my practice.

This gentleman, 41 years of age, had

the misfortune of being struck by a splinter of metal in his left eye, July 13, 1881, about six weeks after he had come to this country. Blindness set in within ten minutes after the accident. He applied on the same day at Wills Eye Hospital, where he was advised to have the eye removed at once. Not quite relishing this prospect, he went to the Jefferson Medical College, where he was admitted for treatment after he had refused the enucleation, which was also at first proposed to him. There he remained for six weeks, during which time the incident inflammation passed off entirely. The globe was preserved, but vision was not restored. He enjoyed good health until March, 1882, when the first symptoms of sympathetic disorders began to develop in the right eye. Asthenopic troubles made their appearance, followed by sensitiveness to light and photopsies. The acuteness of vision gradually diminished as well for distant as near objects.

And now he began his wanderings from one oculist to the other: he hardly spared one, if I have to believe his testimony. Nothing was done for the benefit of the right eye, which changed from bad to worse. Enucleation of the left eyeball was pronounced by all authorities as the ultimate ratio by which the condition of "nervous irritation" in its fellow might possibly be checked.

When I saw the patient for the first time, September 5, 1883, I ascertained the following condition: No irritation whatever in either eye. Vision of the right eye was $\frac{10}{20}$; with convex 40, $\frac{10}{15}$. Pupil of normal shape, but of somewhat sluggish reaction; accommodation is impaired in consequence of paresis of the accommodative muscle. With naked eye, patient reads Jaeger 13 at about fifteen inches' distance; with the help of convex 10, Jaeger 3 at eight inches'. Field of vision and tension are normal. There exists an eccentric positive scotoma outside of the point of fixation. The subjective complaints are of photopsies and scintillations. Ophthalmoscopic examination reveals no morbid changes.

Left eye counts fingers at two feet peripherically outwards. The cornea shows a linear horizontal cicatrix on its lower third, running from the outer corneal margin towards the pupillary region. The lower half of the iris is disorganized, and presents in its middle a funnel-shaped depression, and close to its temporal border a mound-like elevation. The pupillary margin of this segment of the iris is connected by three blackish filaments with the dense opaque whitish membrane which stretches across the whole pupillary plane, filling up the latter to the greatest extent, even after the pupil had been dilated by a mydriatic.

The presence of the above-described "depression and elevation" in the lower half of the iris, which were situated just opposite the corneal scar, aroused my suspicion that the foreign body might possibly lie embedded in this region. An operation for the removal of the foreign body seemed to me to be a matter worth trying at first, by which nothing was risked and everything might be gained. The enucleation of the eyeball I regarded as the last expedient to which I would resort if I should be baffled in my intentions.

I spoke with the patient to this effect, telling him that I must have full liberty to act according to my best judgment, and to be allowed to enucleate the eyeball if I should fail to extract the foreign body.

He took time for deliberation and reflection until May 19, 1884, when he returned in the following condition. In the mean while he had repeated and completed his circuit among the specialists.

Vision of right eye, $\frac{10}{30}$; with convex 60, $\frac{10}{20}$; complete paralysis of the muscle of accommodation. With the naked eye he reads Jaeger 16 at eighteen inches' distance; with the help of convex 10, Jaeger 5 at ten inches'. The shape of the pupil is normal, its reaction sluggish. The visual field is somewhat limited in the upper sector, and its outer-upper quadrant is occupied to the greater extent by the eccentric positive scotoma. Patient sees all objects as through a veil, and is greatly annoyed by photopsies and scintillations, and by the perception of a bluish flame, which constantly occupies the centre of the visual field. He complains, besides, of the most various abnormal sensations in and around the globe, of a feeling of pressure in the depth of the orbit against the eyeball, of pains in temples and forehead, of sensitiveness to light, etc.

The ophthalmoscopic examination reveals venous hyperæmia of the retina. Optic disk is pinkish-red, of somewhat indistinct tints.

The condition of the left eye has not changed.

I operated upon the left eye in the following manner. I made a section at the sclero-corneal border, just within the limits of the morbid changes in the iris, introduced Liebreich's iris-forceps, grasped the whole segment of the iris which contained the "depression and elevation," drew it out and cut it off. No foreign body was found in the excised piece of iris. Now I again introduced a pair of forceps, caught the membrane, which covered the whole pupillary region, and managed to remove it entirely. On inspection, a small oblong piece of metal was found embedded in the posterior surface of the lower end of the membrane. Considerable hemorrhage followed the operation, and a few drops of vitreous escaped from the wound. A compressive bandage was applied on both eyes.

No reaction whatever followed the operation, and the healing process took place most favorably. The bandage was removed on the third day.

When I examined the patient on the eighth day, the condition was as follows: Vision of the right eye, $\frac{12}{15}$; with convex 72, $\frac{12}{12}$. Jaeger 12 is read at fourteen inches' distance with the naked eye. Subjective complaints greatly abated. No photophobia and lachrymation. Scotoma somewhat more transparent.

The left eye shows a very fine artificial pupil. The hemorrhage in the anterior chamber is only partly absorbed. Vitreous contains blood and dense floating opacities.

This remarkable improvement in the condition of the right eye had taken place without any other influences having been brought to bear upon it but the extraction of the foreign body. I abstained from all therapeutics during the eight days, and no more forcible proof of the sympathetic nature of the affection can be adduced than the spontaneous recovery after the cause of irritation had been removed.

An alterative and derivative treatment, which I now instituted, had the following effect. Vision of the right eye is at present $\frac{12}{8}$. The pupil is of normal reaction; the accommodative paralysis has greatly improved. His punctum proximum is at fifteen inches, and he reads, with the help of convex 10, the finest print (Jaeger 1) at six inches' distance. The visual field is normal, and the scotoma has contracted to an oblong rod of about two inches in length and of one-eighth inch in diameter. This scotoma is transparent, and does not interfere with vision. All subjective complaints and perceptions have vanished, with the only exception of the bluish flame, which, however, but faintly and only occasionally appears in the visual field. Background of the eye is normal.

Vision of the left eye is $\frac{1}{10}$, and may possibly improve still more in the future. There still are large floating opacities and some bloody streaks in the vitreous. The background of the eye can only dimly be seen. There are morbid changes in the retina and choroid, due to inflammatory processes which had taken place in these parts.

You have, gentlemen, before you a case in which a foreign body had penetrated into the eyeball, causing traumatic cataract and consequent morbid changes in the uveal tract and retina. The lens is absorbed, and a thick, opaque membrane (secondary cataract) obstructs the whole pupillary region. The foreign body remains embedded in the posterior surface of the lower end of this membrane for nine months, without doing any harm. Then the right eye begins to show symptoms of sympathetic trouble. Amblyopia and paralysis of the muscle of accommodation develop. And while these morbid changes of the most serious character take place, no inflammation proper, no objective irritation, can be observed in either eye. The injurious influences, which have continued to work for two years, are checked at once by the removal of the foreign body. The secondarily affected eye makes a marvellous recovery, which far surpassed all my hopes and expectations. Such a vision of $\frac{12}{8}$ is only met with in very rare instances; and the primary injured eye, which was not considered worth while being preserved, improves to such a degree as to enable the patient, should he have the misfortune to lose his right eye, to find his way in the streets, to recognize faces, to distinguish features, and eventually to gain a living by peddling, etc., if need should be. This case may justly be called a triumph of conservative surgery.

I take exception to the practice of all those surgeons who resort without further delay to enucleation in instances of injury to the eyeball with loss of vision. In

all cases in which there is no foreign body in the interior of the globe, we should abstain from operative interference and watch the eye with care. There is no danger in waiting. Sympathetic irritation is not likely to occur immediately after the injury. Enucleation itself is not so harmless as it is generally represented in text-books. It may sometimes give rise to sympathetic irritation, and I would impress this fact upon the general practitioner. It is not indifferent to the patient whether his blind eye be removed or not. A blind eye looks, in the greatest majority of cases, better than the artificial one, and we have to give to the patient the benefit, as long as it is compatible with the safety of the other eye. It is a matter of æsthetics. If a foreign body has penetrated the eyeball, the first indication is to remove it with an electro-magnet. If it cannot be found, and there is traumatic cataract, I would at once remove the latter: the body may be embedded in it. Should this removal fail, I advise enucleation at the same sitting. The foreign body extracted in this case was about three millimetres long, and of metal.

HYDROCHLORATE OF COCAINE IN AURAL AND OTHER CASES.

BY H. C. BOENNING, M.D.

ON November 3, 1884, I was requested to call on Dr. L. R. K. and remove a piece of cinder that had been embedded in the cornea. I found on examination that the cinder was firmly fixed in the cornea and surrounded by an area of discoloration. Efforts at extraction provoked intense suffering, and I determined to use cocaine to test its anæsthetic virtues. I obtained a weak solution from Dr. L. W. Fox, and dropped four drops every three minutes into the eye, using sixteen drops. In a few minutes the pupil dilated and the cornea was insensible. I removed the foreign body without causing the slightest pain. The cornea continued anæsthetized for nearly two days; the pupil remained dilated for a day longer, but gradually returned to the normal. Accommodation was not interfered with to any extent, J. No. 1 being read with the aid of the patient's ordinary glasses at ten inches. A curious symptom observed was a marked dryness of the throat and mouth, which passed off in the course of a day.

Since then I have used the cocaine in other eye cases. In a case of ulceration of the cornea accompanied with severe pain, the instillation of the cocaine was followed by a marked relief of all pain and a diminution of the attendant conjunctival injection. The photophobia present was not influenced by the cocaine; severe suffering was produced by exposure to light; but the constant pain attendant on the ulcer was relieved. The next day I tapped the anterior chamber, and the patient is now well.

About the middle of last month a child was brought to my office for ear-trouble. The history revealed an attack of scarlet fever two years ago, followed by deafness and a discharge from the meatus. An examination proved marked loss of hearing, but I could not determine anything more, the slightest contact with the ear producing pain and exciting the girl so much that the mother interfered. I ascertained that discharges of blood occurred from time to time, and that at first, when the child held her nose and mouth and expired, a hissing noise in the ear could be heard. I obtained the child's consent to an examination if it could be done painlessly, and forthwith used a strong solution of cocaine (eight-per-cent. solution), dropping about thirty drops of this into the ear in the course of half an hour, although much of the fluid overflowed the meatus. Ten minutes after the last drops were used I opened the meatus with a small bivalve ear-speculum and found it contracted by a growth—which partly filled the canal—of a pale-reddish color, bleeding slightly upon touch. The child (Mabel C. L.) felt the manipulation, but no pain was produced. Forcible expiration produced a hissing sound, and my diagnosis—vascular polypus with perforation of the membrana tympani and chronic catarrh—was confirmed. The next day the patient appeared for operation, and after using the cocaine again (although the parts were still numb) I removed the growth and washed out the ear, no pain of any consequence being caused. The case is progressing excellently, and I hope soon to close the perforation, which is near the lower portion of the membrane, being a circular hole with thickened edges.

My own child—a boy 26 months old—a week ago developed a small follicular abscess of the meatus auditorius, accompanied by pain, feverishness, and wakeful-

ness. I used the cocaine in his case twice in twenty-four hours with much relief. The next day I opened the abscess, which, of course, permanently relieved him.

November 5, Mr. Barcus, a student at medicine, kindly permitted me to drop some cocaine solution into his ear, the result being similar to the above cases. The canal was benumbed. A probe and speculum, which in the other ear caused pain when twisted or moved from side to side, was felt in the anæsthetized ear, but no pain was caused.

I would note, in no case were any unpleasant symptoms produced except in that of Dr. K., where dryness of throat was marked. This may, of course, have been a mere coincidence. In ear cases the solution should be much stronger than in eye cases, otherwise the effect will be neither so prompt nor so satisfactory.

528 Franklin Street.

NOTES OF HOSPITAL PRACTICE.

UNIVERSITY HOSPITAL.

SERVICE OF WM. PEPPER, M.D., LL.D.,

Provost of and Professor of Clinical Medicine in the University of Pennsylvania.

Reported by William H. Morrison, M.D.

CHRONIC INTESTINAL CATARRH.

GENTLEMEN,—I wish to again show you the man suffering with chronic diarrhœa whom you saw some time ago. He is now much improved. As you will remember, he has been suffering from a general catarrhal inflammation of the mucous membranes for at least eight years. There is probably in this patient a constitutional predisposing tendency to this affection; for without any unusual exposure he passed into this condition of catarrhal inflammation. Eight years ago, as a result of some little indiscretion, he began to suffer with dyspepsia. After three years he recovered from this attack, but was still subject to spells of dyspepsia on the least impropriety in eating. For the past two years he has been suffering with this irritation of the mucous membrane, chiefly of the larger bowel. When the irritation would subside, there would be atony, defective secretion, and constipation; then would follow colicky pain, griping, purging, and anorexia. This would pass away, and a state of constipation and torpor succeed. So it has been, up and down, for the past two years; but, on the whole, his course has been steadily downwards. The stools were liquid, and largely mixed with mucus. At times they would consist almost entirely of mucus, with but little fæcal matter.

The location of the pain, the considerable amount of mucus in the stools, the fact that gastric digestion was not much affected, and that there was not nearly as much prostration of the general health as we should have expected had the disease involved the higher portion of the alimentary canal,—all indicated that the disease was chiefly in the larger bowel.

In considering this case, I pointed out to you the great importance of rectal medication, and that in many instances the use of suppositories or enemata was the only way in which the disease could be cured; and that, under this plan of treatment, the recoveries were often remarkable, while the continued use of medicines by the mouth might prove ineffectual. By this plan the stomach can be reserved for the administration of tonic remedies.

In this case I ordered an injection of four ounces of water containing one grain of nitrate of silver and fifteen drops of deodorized laudanum to be thrown into the bowel, and the following to be administered by the mouth:

℞ Strychninæ sulph., gr. ⅓;
Acidi hydrochloric. dil., ʒij;
Tinct. gent. comp., q. s. ut ft. ʒiv. M.
Sig.—A teaspoonful before meals.

Under this treatment, decided improvement has taken place. The tongue looks better, and the diarrhœa is not so marked. The treatment will be continued. The restricted diet will still be insisted on, and the patient kept in bed most of the day, being allowed to be up a short time to take moderate exercise.

I have seen a number of remarkable results from even such simple injections as the one used in this case. A chronic dysentery is sometimes kept up by a trifling patch of inflammation in the rectum or sigmoid flexure. I have had a number of patients come to me who had been under treatment for years. They would have two or three loose stools in the morning, and then be comparatively comfortable all

through the day. Change of diet would have but little effect. There would be some colicky pain across the lower part of the abdomen and in the line of the large intestine, and not much about the umbilicus; the appetite pretty good, and the tongue clean, although rather pale. I have seen such cases which had existed many years, and in one of them the disease had lasted fifteen years, and had resisted all kinds of remedies. Thinking that there might be some inflammation of the lower bowel, I have ordered a few injections, and have had the patients return in a short time, stating that they had been cured by eight or ten injections of a simple character, so that it would scarcely seem credible that such long-standing trouble had been present. Of course, these are rare cases. There are, however, many cases of chronic diarrhœa which are beyond the influence of remedies administered by the mouth; and it is not until, by the use of medication addressed to the rectum, we have relieved some local catarrhal irritation, that we are able to effect a permanent cure.

Where the rectum is very irritable, and particularly where there are associated with it internal hemorrhoids, and possibly a disposition to looseness or diarrhœa, I wish to refer to the value of hot injections into the rectum, and especially such injections with the addition of some astringent. I know of no substance which is more agreeable as an enema than coffee. From half a pint to a quart of strong black coffee may be used, as hot as will be tolerated by the rectum. You have seen the beneficial effects of hot water in external inflammations in the form of hot-water dressings, in catarrh of the stomach in the form of hot drinks, and in uterine inflammation in the form of hot-water injections. In these cases of congestion and catarrh of the lower bowel, a good plan is to give in the morning an injection of hot water, and then at another period of the day, as at night, a second small medicated injection, and have the patient go to sleep and retain it.

On the other hand, I also want to call attention to the value of very small cold injections into the rectum in cases of irritable rectum. An injection of two ounces of water, as cold as the patient can bear without giving him a chill, retained all night, will sometimes act magically in relieving the irritation disposing to frequent discharges.

All of this simply goes to show the value of enemas adapted by your judgment to the different conditions of the system, and particularly the different local conditions: these constitute a valuable measure of controlling many conditions which too often are treated with medicines given only by the mouth, which never reach the spot.

IMPACTED CALCULUS.

This patient, a shoemaker, drank a great deal as a young man, and has drunk more lately. He has never had any venereal disease, but has been exposed a great deal; his habits have been irregular. Twelve years ago he had smallpox, and this was followed by rheumatism. Since then he thinks that his health has not been as good as before; but his dissipated habits may account for this.

Fifteen months ago he was much exposed to the wet, and, after about a week of general chilliness and discomfort, he began to have sharp darting pains over the crest of the left ilium, which grew worse and in a few days settled over the left kidney. The pains extended down the left groin, but not into the penis or testicle. There was also a constant desire to pass water, and the effort increased the pain. He got better, but still had soreness over the left kidney and along the crest of the ilium. Exercise and bad weather made this worse. At times he would have sharp spells of pain, and at such times would pass very little water. Four months ago he had another violent spell, and micturition became frequent and painful. Then he took a strong mixture of turpentine, and passed blood for several days. This acute attack subsided, and he returned to pretty much his usual state, except that he was more broken down. Before he came into the hospital, he had a similar attack, again took turpentine, and again had hemorrhage. On admission, there was pain over the left kidney, and darting and sticking pains ran around the crest of the left ilium. There was frequent micturition, but when the urine was examined it was found to be normal. The general health was run down. There was a distressing cough, and there was pain over the left lung. Physical examination revealed friction-sounds at the base of the left lung, and pericardial friction-sounds, a mitral

systolic murmur, and also a mitral presystolic murmur. There were evidences of pericardial adhesions in retraction of the tissues during systole. The lung did not advance over the heart during inspiration. There is a constant dull pain in the region of the left kidney and along the crest of the ilium, but there is no evidence in the urine of pyelitis. There have been several attacks of hæmaturia, and the blood seems to have come from the left kidney. This would suggest that there was a calculus in the left kidney; but there has been no continued evidence of inflammation of the pelvis of the kidney. Pyelitis reveals itself not only by pain, tenderness over the kidney, and attacks of lancinating pain in the line of the ureter, but also by changes in the urine, which throws down a considerable amount of pus, the supernatant liquid containing albumen rather in excess of the amount of pus present.

From the symptoms present, I am inclined to think that there is a calculus impacted in the substance of the kidney, and that attacks of congestion occur around it, which relieve themselves in the hæmaturia. As the stone has not gotten into the pelvis, pyelitis has not been established.

The progress of the case has not been satisfactory. He has been losing weight. Examining the lung, I find, at the left apex, impaired resonance and diminished fremitus, the vesicular murmur being absent. At the right apex there is marked resonance, and the respiration is rather puerile. There is a harsh systolic murmur over the apex, and friction-sounds are heard over the base of the heart.

The man, to-day, has a temperature of 102.5°. His tongue is clean, but rather glazed, and vividly red. Along its edges will be seen a number of pearly-white spots, which are very painful. These are minute aphthous ulcers, and, when they appear at a late stage of a chronic wasting disease, they are of bad omen. They are, however, not sufficient of themselves to justify an unfavorable prognosis; but in cases where you have been dreading deep-seated organic trouble, whether febrile or not, and you find aphthæ beginning to form in the mouth, it is of most unfavorable omen. In addition to the elevation of temperature, there is excited action of the heart, and the friction-sounds at the base of the heart are more marked than they were yesterday.

I cannot divest myself of the idea that this is a renewal of the disease at the base of the heart. There is considerable heaving and throbbing of the root of the aorta, and there are marked friction-sounds, and there is pain and tenderness on pressure being made over the base of the heart. There is, in all probability, a renewal of the disease at this point, which I regard as probably rheumatic in type. There is no evidence that the pulmonary disease is progressing.

I shall order a blister, three inches square, to be placed over the base of the heart, and shall give him the salicylate of sodium, in eight-grain doses, every three hours; and, by the rectum, twelve grains of cinchonidia, morning and evening. The efficiency of the salicylate of sodium will be increased by the addition of two drops of tincture of aconite to each dose.

TRANSLATIONS.

TREATMENT OF PHTHISIS WITH ACETATE OF LEAD.—Dr. Biedert, in the yearly report of the hospital at Hagenau, gives a number of cases of hæmoptysis which had been treated with acetate of lead. There were altogether ten cases, ranging in age from 15 to 46 years, suffering from severe and obstinate hemorrhages. The causes were phthisis in seven cases, chronic pneumonia in two, and acute pneumonia in one case. The drug, exhibited in doses of from 0.03 to 0.05 gramme every two or three hours, acted so promptly in arresting the hemorrhages that the author considers acetate of lead as the strongest and most satisfactory hæmostatic known. In seven of these cases the other usual remedies, such as ice, acids, alum, with narcotics and ergotin injections, had been used without result, and the hemorrhages had continued for considerable time before the acetate of lead was used. In three others the drug was given at once, and in all the cases the hemorrhages ceased in from twelve to thirty-six hours from the beginning of the treatment.

If the cough should be severe, the author advises combining the acetate of lead with opiates, and to continue the exhibition of the acetate of lead in gradually-diminishing doses for several weeks after the hem-

orrhages have ceased. A severe lead colic was not observed in any of the cases, but should such be the case the lead should, of course, at once be withdrawn. A like prompt action was observed in a case of obstinate renal hemorrhage in a child suffering from acute nephritis.

[This experience of the above observer is, however, not borne out in this country, since even larger doses of acetate of lead than those he mentions have failed to give as good results in checking hemorrhage as the usual combination of ergotin and opium. S.]

NON-PARASITIC CHYLURIA AND CHYLOUS HYDROCELE.—M. Le Dentu, at the Société de Chirurgie, recently read a paper on the filaria sanguinis hominis and the pathogenic *rôle* of this parasite in fatty hydrocele, in which, after reviewing the history of the discovery and defining its limits, he refers to another class of cases in which no parasite exists. He concludes as follows:

1. If it is demonstrated that parasitism is the real cause of a certain number of chylous effusions and of chyluria, without prejudice as far as other lesions are concerned, it appears certain that the parasitic theory is not applicable to all cases.

2. To this special cause should be added others, of which some are due to a general cause (peculiar alterations of the blood), some purely local in their origin (ruptures or compressions upon any point whatever of the lymphatic system).

3. Such compressions, whether affecting the thoracic duct or the principal lymphatic trunks, act as partial or total obstructions to the ganglia, and produce either a transudation or rupture, and, unless absorbed, an accumulation of lymph either in the tissues or in closed cavities.

4. It is by obstruction of the ganglia, of the trunks and their branches, that the filaria causes all the disorders attributed to it. Treatment of the parasitic form is therefore rendered unsatisfactory by the nature of the case.

PRECAUTIONS TO BE ADOPTED IN THE TREATMENT OF PHTHISIS.—At the International Congress of Hygiene held at La Haye in September last, the following conclusions were adopted regarding the treatment of phthisical patients, after an interesting discussion upon a report presented by Prof. Sormani, of Pavia.

"It is demonstrated that pulmonary phthisis can be, in certain cases, transmitted from the sick to individuals in health. Although the chances of this transmission are limited, prudence requires certain precautions.

"1. No one should be allowed to share the sleeping-chamber or the bed of a tubercular patient in an advanced stage of the disease. The apartment of a phthisical individual should be constantly aired and ventilated.

"2. The danger resides especially in the sputa, which should not be allowed to go on the floor or on clothing, where they may dry and become converted into dust.

"3. The sleeping-rooms, the bed-linen, and clothing which have been used by consumptives should always be disinfected. Steam (at 100° C.) and washing in boiling water are the best means of disinfection.

"4. Convalescents from chest-disorders and feeble and exhausted patients should especially avoid prolonged contact with the tuberculous."—*Revue de Thérapeutique Med.-Chir.*, No. 23.

HERPES ZOSTER AND FACIAL PARALYSIS.—Dr. E. Voigt, in the *St. Petersburg Med. Wochenschrift*, relates at length an interesting case of acute herpes zoster (occipito-collosis) complicated with grave peripheral unilateral facial paralysis, and comes to the conclusion that herpes zoster is not necessarily dependent upon disease of the spinal ganglia, but, as in this case, may be caused by local neurosis of the sensory nerve-fibres. The case was treated by galvanism, with very good results as far as the pain and tinnitus aurium were concerned, but the facial paralysis was but little benefited. S.

HOMATROPIN AND GLAUCOMA.—In the *Centralblatt für Praktische Augenheilkunde*, September, 1884, is reported a case of incipient glaucoma produced by homatropin, occurring in the practice of Dr. Theodor Sachs, of Innspruck, in which eserine speedily brought about a return to the normal condition. This case is interesting from the fact that it seems to be the first one on record in which homatropin has produced glaucoma, and also on account of the prompt antidotal action of the eserine. S.

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EDITORIAL.

1884—1885.

WHILE the annals of medical science during the last twelvemonth were not distinguished by any especially brilliant achievement or epoch-making discovery, yet it may be truly said that satisfactory and solid progress in rational medicine, conservative surgery, and the applications of sanitary science has undoubtedly been made by the profession as a whole. Within the limits of a brief article we cannot hope to do justice to the topic, but it may be interesting, as it certainly is timely, to cast a cursory glance over some of the prominent features characterizing the *annus medicus* through which we have just passed.

In the first place, upon calling the roll we miss many representative members of the American medical profession who responded *Adsum!* at the beginning of last year,—Samuel D. Gross, Willard Parker, J. Marion Sims, L. A. Dugas, S. M. Bemiss, J. G. Thomas, Lunsford P. Yandell, J. J. Woodward, Robert E. Rogers, Joel Foster, William Darling, Edward Jarvis; and, in Europe, Prof. Cohnheim, Reichert, von Zeissl, Balfour, Allen Thomson, Dumas, Wurtz, Tweedie, Radcliffe, Jäger, Sir Erasmus Wilson, Charles Clay, Frederic A. Mahomed. How the sad list extends! Death, who loves a shining mark, crowns the memories of 1884 with the myrtle rather than the laurel.

Turning to affairs of public health, we observe the increased interest in the meetings of the American Public Health Association, and as an indication of advance in such matters we may cite the formation of an American Society of Public Analysts during the past year. The existence of cholera in epidemic form in Italy, Spain, and France, and the prospect of an early outbreak in this country, have stimulated health-boards to increased activity, and suddenly inspired health-officers to new zeal in their work. The public interest in the subject finds expression in a bill now before Congress to re-establish a National Health Board, which has a fair prospect of passing, as it has been reported upon favorably in committee.

In surgery, the advance in knowledge of the results by operative interference in intra-peritoneal disorders has been decided. The carbolic spray is now rarely used, surgeons having learned that the peritoneum is far less vulnerable than was supposed, cleanliness, operative skill, and care in the after-treatment being the essentials. In this connection we must notice the operation recently performed by Dr. Sutton, of laparotomy and resection of the bowel for artificial anus, said to be the first operation of this kind performed in America. Cerebral surgery has also had a triumph in the localization by Dr. Hughes Bennett of a cerebral neoplasm under the dura mater, and its successful removal by Dr. Godlee in London. A passing reference only can be made to naso-pharyngeal surgery, but we cannot refrain from calling attention to the successful treatment of hay-fever by the removal of nasal hypertrophies, for which we are indebted particularly to Dr. J. O. Roe, of Rochester, and J. N. Mackenzie, of Baltimore.

The problem of the successful application of the electric light in a practicable form for diagnostic purposes seems to have been satisfactorily solved during the past year by the lamp of the S. S. White Manufacturing Company, which promises soon to be a part of the necessary armamentarium of the physician, as the companion to the speculum and laryngeal mirror.

In matters more directly medical there

is less to report. It can scarcely be said that the germ-theory has advanced greatly during the year. It is true that many new "germs" have been discovered, and attempts made to enlarge the list of zymotic disorders by the addition of many diseases, including eclampsia and alcoholism, but there has not yet been furnished the demonstration that microbes are the direct and sole causes of specific diseases. Nor can it be claimed that the recognition of these organisms—as, for instance, the bacillus of tuberculosis—has greatly aided our therapeutics: it might indeed be said that such therapeutic deductions as have been made from the germ-theory of disease have, in the main, failed to be endorsed by clinical experience. There has been a quiet but steady advance in general pathology during the year, which is probably most evident in diseases of the nervous system. A better prognosis is held for locomotor ataxia, and brain-lesions are more readily recognized and are treated with better chances of success than they were a year ago. Among the therapeutical advances we must include Da Costa's abortive treatment of erysipelas with hypodermic injections of pilocarpine, which has yielded striking results in his hands and promises to be a decided acquisition to practical medicine. The great event of the year was beyond doubt the introduction of the hydrochloride of cocaine into ophthalmic surgery by Koller, of Vienna, and its extension to other uses by a host of clinical observers who are enthusiastic in its praises. We might also speak of the introduction of antipyrin as a substitute for kairin as an antipyretic, but, as it is a preparation which has been kept secret, we think it advisable that the profession should exercise some caution in using it and in recommending its use. Etherization by the rectum had a very brief existence, and has now, we think deservedly, fallen into disrepute.

Among the most inviting problems for the pathologist during the coming year are the etiology of cancer and the unification of the different and conflicting views of tubercle, while the rational treatment of pulmonary consumption and cholera will continue prominently to engage the attention of the clinical investigator.

In beginning the new year, it is a subject of sincere congratulation to the profession throughout the entire country that the Code controversy has ceased to disturb the harmony of the New York medical societies, which now are free to continue their scientific work unhindered by ill-advised and ill-timed attempts to elevate the medical profession.

THE ABUSE OF ANTIPYRETICS.

BY physicians of sufficiently broad views to recognize "not only the disease in the sick man, but the sick man in the disease," the growing practice, which prevails more particularly in Germany, of administering enormous doses of antipyretics, is viewed with feelings of distrust, not unmingled with alarm. In a discussion at the French Academy, Professor Peter charged the advocates of the antiseptic or germicide treatment to be careful "lest in lifting a club to kill the germs they knock down the patient." Surely this warning was not given without sufficient cause. From the study of thermic fever, and of the effects of high bodily temperature upon animals, knowledge of unquestioned value has been derived, but from a hasty application of this knowledge to clinical medicine there has resulted an evident tendency to look upon fever as simply an excess of bodily heat, the object of treatment being mainly to restore the temperature to the normal; hence remedies capable of acting powerfully upon the nervous system, depressing calorification and assimilation, are largely used. That this view is so generally held is due largely

to the adoption of the views of Liebermeister.

Granted that hyperpyrexia adds an element of danger to the case, which sometimes makes it essential that the overheated blood and tissues should be relieved as rapidly as practicable, it does not follow that ordinary cases of fever require or will be benefited by toxic doses of quinine, salicin, salicylic acid, kairin, antipyrin, etc., which have been so highly vaunted. Professor Da Costa, in discussing the general management of fevers,* calls attention to the fact that it must not be inferred that massive doses of sulphate of quinia are to be employed in all the fevers of the continued type, and says that "such large doses cannot be given with impunity in various and dissimilar conditions; and it is very possible that while they reduce the temperature they may aggravate the disease or some of the lesions."

In a discussion upon this subject at the last meeting of the British Medical Association, Professor Gairdner† expressed a similar opinion, and, while not opposing the careful and judicious use of antipyretics, or of any other remedies, "he could by no means admit that the one object of treatment in an acute disease was to keep down the temperature by hook or by crook. It was impossible to regard the human body, in an acute disease, as a mere mass of overheated tissues, or to suppose that by merely cooling it down outside one could restore health and function when otherwise fatally disabled. When it was said that one must absolutely cool down the patient till it became necessary to give him stimulants to set him up again, he thought that the limits of safety in antipyretic practice had probably been exceeded. When it was said that, failing the cold bath, it was necessary to give enormous and repeated doses of quinine, and, failing these, enormous and certainly dangerous doses of digitalis, aconite, and even veratria, with the single object of getting down and keeping down the temperature, in diseases certainly admitting of fairly successful treatment without nearly so much interference, he confessed that he thought that the practice of medicine was running in a wrong direction, that they were likely to have the story of the past repeated once more,—a time of energetic and active practice (so called),—that is, of extremely powerful, and in some cases dangerous and even poisonous, remedies, so advocated as to make them appear indispensable, and to place them as such in the hands of every one all over the country." Feeling that such a custom was likely to run into abuse, Professor Gairdner entered a vigorous and timely protest against it, which may well be heeded by practitioners in this country.

It is noteworthy that at the last meeting of the Society of Physicians in Vienna Professor Nothnagel likewise called attention to the prevailing error of regarding fever as a disease *per se*, which is to be treated by any and every means that may influence it. He offers the pertinent suggestion that fever may often be a salutary process, and, in fact, is one of nature's regulative means. It is not evident that acute febrile diseases are shortened by simply diminishing bodily temperature, and therefore the routine or indiscriminate administration of antipyretics, based upon the single symptom of elevation of temperature, is unscientific and unsafe.

THE EXECUTIVE COMMITTEE OF THE AMERICAN PUBLIC HEALTH ASSOCIATION met in Washington, December 11, 1884, to make arrangements for the meeting in December. Subjects were selected for prize essays, and the Committee on Disinfectants was authorized to publish a preliminary report in view of the possible advent of cholera.

* Introductory chapter to Dr. J. C. Wilson's Treatise on the Continued Fevers. New York, 1881.

† British Medical Journal, p. 1124.

NOTES FROM SPECIAL CORRESPONDENTS.

LONDON.

THE medical world here has recently been saddened by the death of one of our most promising young physicians,—Frederic Akbar Mahomed, of Guy's Hospital. Though only thirty-six years of age at his untimely death, Dr. Mahomed had for a number of years been a conspicuous figure in our ranks. Even as a student he won regard, no less from his general assiduity than by his work with the sphygmograph, then beginning to attract attention. He had not long been qualified when he was appointed resident medical officer to the London Fever Hospital. Here he worked hard at the matter of arterial tension, having the advantage of the supervision of Dr. Broadbent, Visiting Physician to the Hospital. To speak broadly, Dr. Mahomed found a rise of arterial tension to precede uræmia, especially in the kidney-complications of scarlet fever. Consequently he reasoned that if a brisk purgative were given to remedy the waste-laden condition of the blood, distinct uræmic symptoms might be averted. And practice proved the assumption to be correct. Since then, Dr. Mahomed's name has been closely linked with the subject of arterial tension, and much of our present knowledge of the significance of conditions of high tension is owing to his exertions. When he left the Fever Hospital he became Medical Tutor at St. Mary's Hospital, and after that Pathologist to the School. Here a sad incident occurred. He had to make an examination of a patient who had died of scarlet fever, and the result was that he took the infection home, where his wife lay just confined. She caught it and died, leaving him with two small children. Such a blow would have damped the energies of an ordinary man, but Dr. Mahomed never flinched from his duties, and worked indefatigably at his post. Soon an opportunity offered itself for his rejoining his old school,—Guy's. While Medical Registrar there, he saw it would further his end of gaining a place on the staff of that hospital to possess the M.B. of Cambridge. He had already supplemented his qualifications to practise by taking the M.D. of Brussels. He acted with his wonted energy. In order to qualify for his degree, he must reside so many terms at Cambridge. So Dr. Mahomed "went into residence" by taking his rooms and sleeping each night at Cambridge, while he continued his duties in the day as a Registrar at Guy's and an Assistant Physician at the Fever Hospital. And all this time he was earning his bread and maintaining his two little ones by teaching and writing. Such labors would have crushed most men; but Dr. Mahomed through it all presented the same erect carriage, the same elastic spirits, the same cheery demeanor, the same readiness to enter into any medical topic which might be exciting attention. And during all this time he was making valuable additions to our literature, his essay on "The Pre-Albuminuric Stage of Bright's Disease" having an especial interest at the present time, when our views on albuminuria are in a state of change. Dr. Mahomed attained his aim of becoming attached to the school of Guy's Hospital, where his diligence and his enthusiasm communicated itself to others. His teaching was sound and practical, while his belief in the efficacy of remedial agents was of the greatest service in a school where therapeutics were too little esteemed. Students found they could learn much from him, and Dr. Mahomed ever held his stores of knowledge at the disposal of his pupils. Liked, esteemed, looked up to as one who would occupy a commanding position, he was doing good work in his time and generation in his hospital and its school, and was also Physician to the Fever Hospital. Surely all this was work enough for one man. But Dr. Mahomed found time to be the moving spirit of the "Collective Investigation" movement of the British Medical Association, and was one of the Secretaries. The aim of the movement was to utilize the vast body of the Association by eliciting the opinions of its members on certain subjects, circulars being issued and widely circulated. The movement is thus far yet in its infancy, too much so to permit any positive opinion being formed of its usefulness or its comparative inutility, about which opinions differ widely. That something would have come of it if the man who more than any other was responsible for the movement had only lived to nurse his bantling is certain enough; but what may be its fate now is uncertain. In furtherance of his object, Dr. Mahomed went to the recent international meeting at Copenhagen, and set on foot an International Collective Investigation Committee. Shortly after this he took ill of enteric fever, how caught no one can say, and the attack was a severe one. Hemorrhages occurred and recurred, with the untoward result that the strong, courageous man lay still in death. The announcement of his death took many by surprise, for a man may be sick unto death in this large city, and few even of those who entertain warm friendly feelings for him know aught of it until there comes the startling rumor of his impending death, or more often the staggering announcement of his death in the obituary columns of our newspapers. The event is all the sadder that, with his wonted sanguine temperament, Dr. Mahomed had just moved into a large house, suitable to his position and prospects, in Manchester Square. Few men so young have been so universally regretted.

Not long ago, Dr. Broadbent was speaking of him as a remarkable man, not only for work in himself, but for his singular power of inspiring work in others. Prof. Humphry, of Cambridge, has borne his testimony in the *British Medical Journal* to the invaluable work he has done in the Collective Investigation movement. And, last week, one of those who were hostile critics of the movement steps forward at once to honor the man who set it on foot, and gives it as his opinion that the present is an opportunity for making a start in a new direction,—viz., out of the large and fast accumulating funds of the British Medical Association to grant to Dr. Mahomed's widow (he had married a second time) and children a yearly sum. The suggestion ought to meet with wide-spread adoption by the Association, for Dr. Mahomed had peculiar claims upon the Association, and every one who has its success at heart and would be glad to see it flourish in every way will be glad to see the suggestion carried out. Certainly, if ever its funds are to be utilized to grant pensions to the widows and children of those who have died in its service and wearing its harness, the present is a case in point. And, fortunately, Dr. Mahomed, with all his energies, made many friends and but few, if any, enemies, being singularly happy in the last in this jealous world.

Personally, I think some such recognition of what Dr. Mahomed did for the profession in general and the Association in particular is eminently desirable, and its rulers would do a graceful act if they granted a yearly sum to those who depended for their all upon a zealous worker well known to them.

Dr. Mahomed was a man of stalwart frame, tall and commanding in appearance, full of energy, who made his presence felt in any company. Those who were present at the Worcester meeting of the British Medical Association will not readily forget him when the meeting to discuss the compulsory notification of disease was falling into confusion and losing its way in propositions and counter-propositions. Dr. Mahomed, with his towering presence, his loud, ringing tones, and clear exposition, put all on the right track, and enabled the meeting to speak its mind and express its views, when, without him, in all probability, the meeting would have ended in "confusion worse confounded."

And now something may be said as to the practical aspects of one item of the life-work of this ardent student. His work with the sphygmograph led him to apply the instrument to the pulse in post-scarlatinal conditions, with the result that he discovered a rise in the arterial tension to precede the oncome of uræmic convulsions. This rise he attributed to the presence of excrementitious nitrogenized materials in the blood, not being efficiently cast out by the kidneys and accumulating in the blood. The well-known high arterial tension, the sustained pulse (full between the beats), with its characteristic square-headed tracing, of gouty conditions stood in a most suggestive relation to this pre-uræmic rise of tension in post-scarlatinal states. When uræmic symptoms are developed, it is the practice to act freely on the bowels, or nature spontaneously sets up diarrhœa, by which the defective action of the kidneys is vicariously supplemented and the uræmic condition relieved. The natural inference was that if such vicarious action were set up before the oncome of the uræmic state, it might be avoided, and such was the result in a sufficient number of cases to justify and corroborate the view. But behind the direct result of his acumen lay indirect results which did not escape Dr. Mahomed's vision. He made a study of Bright's disease, the correlative of the nephritic state left by scarlatina. Here also there is imperfect secretion of nitrogenized waste, accumulation of it in the blood, and sundry consequences of this, as serous inflammations and serous effusion into the brain. Excision of the kidneys of serpents is followed by a deposit of urates in the serous membranes, and in mammals extensive disease of the kidneys is commonly followed by morbid changes in the serous membranes. The rise in arterial tension in such cases is found to lead in time to hypertrophy of the left ventricle and accentuation of the aortic second sound. Not only are the semilunar valves closed violently, but on the arterial recoil the whole of the aortic root is violently distended, with the result very frequently of valvulitis being set up, followed by regurgitation through the injured valves. The distention of the arterial system leads to the development of atheroma throughout the arterial walls, and these hardened, brittle walls are liable to be cracked, with the formation of an aneurism, or maybe, if the rupture take place in the cerebral vessels, a blood-clot is formed, constituting apoplexy, or a stroke. Such association was observed as a matter of fact in the pathological room by Rokitansky long before the cause of the association, or *zusammenhang*, had been investigated. Then to these are added times when the accumulation of the azotized waste in the blood leads to acute uræmic evidences, or at other times to paroxysms of angina pectoris vaso-motoria. Angina is now known to be linked with vaso-motor disturbance; there is contraction of the arterioles, a damming of blood in the larger arteries, distention of the aorta, and, behind that, distention of the left ventricle. Sometimes the condition becomes so pronounced that the ventricle comes to a stand-still in diastole, unable to contract upon its contents, exhausted in its effort to overcome the resistance offered to the onward flow of the blood by the full state of the aorta. All these morbid states are the outcome of a waste-laden condition of blood.

Now, how is this primary condition to be met? Experience has told of the utility of cathartics. The rule of the older men, when they experienced a tight artery, was to bleed, if the condition was serious, and so to reduce the bulk of the blood, getting rid of so much waste matter with it. In less grave states the practice was to administer a blue pill and a black draught, and so "sweep out the liver," as they termed it. And very good practice this was in a great variety of obscure conditions, as John Abernethy found. It was not the use of such treatment which led to its abandonment; it was the abuse of it. When Abernethy encountered certain conditions of a somewhat confusing character, he recognized that a morbid state connected with the liver underlay them, and by the administration of a mercurial followed by a purgative distinct amendment was the result. Very commonly, dark, offensive motions, copious in bulk, were voided, and "inspissated bile" was a term then in common use. Such was Abernethy's practice, and his results, when published, led many others to follow his example. Ere long the blue pill and black draught were the fashion, and were resorted to in season and, what was worse, out of it. The wide-spread resort to such powerful medicaments led to much undesirable result. Doctors employed the heroic measure in unsuitable cases. Persons who suffered from "Liver" resorted to it habitually, and made it the excuse for a dietary far beyond their actual requirements, flying to the blue pill and black draught when "out of sorts," until a reaction set in and Abernethy's line of practice fell into disrepute. But, all the same, the pendulum is swinging back again; and now some of us at least know by experience the excellent effects of a mercurial followed by a purgative whenever the blood is surcharged with nitrogenized waste. And for this we do what the older men did,—viz., "feel the patient's pulse" first, and, finding it tense, take our measures accordingly.

Now, what Dr. Mahomed did was to give scientific precision to such observations. The sphygmograph writes down legibly and records what the trained finger feels, and so can convey a visible impression to others,—a matter of the highest value in teaching. When the student saw the sphygmograph-tracing before the eliminant treatment and after, he had a tangible proof of cause and effect. This is to him much clearer and more distinct than a careful interrogation of the patient's subjective sensations (a matter rather at a discount in medical teaching at the present day), and the tracing of high tension contrasted with the more normal tracing given by the artery after the blood had been cleansed.

Such, then, is a wider outcome of the research with which Dr. Mahomed's name will remain indissolubly connected. Of course he was not alone in the field, but his work stood on such a solid basis of individuality, and his observations were conducted on such a clear, unmistakable line, that his position was at once prominent and permanent. His loss to Guy's Hospital is great. It is not that Guy's has not on the list of its staff some admittedly able men; but it lacks that galaxy of talent which once shone over it and constituted it the finest school of medicine in England, certainly. Guy's has known evil times. The distinguished men who once gave it such prominence have passed away, and were not replaced,—from no fault of any one's, for Guy's never followed the rule which has worked so disastrously at some schools, of sending away its talent and then starving for want of it. Then it has suffered from civil strife, and been made the battle-ground of a fierce contest betwixt an arrogant sisterhood and the medical staff. It has its funds crippled by agricultural depression and political agitation in Ireland, where much of its property is located. Yet, with all this, it held its ground as the school whither the well-to-do general practitioner sent his son, if the youth hankered after his father's profession. But it has just lost Hilton Fagge, a man of weight on the teaching staff; and now a greater calamity has befallen it in the death of a man who not only held a conspicuous position in the great Borough school, but who had at an early age drawn the gaze of the medical world upon him by his actual achievements and the promise which lay in him. His profession regrets the loss it has suffered, and, beyond this general regret, there is that of those who enjoyed his personal friendship and who knew the sterling worth of the man. A movement is already on foot to secure some lasting memorial of him.

J. Milner Fothergill.

PROCEEDINGS OF SOCIETIES.

NEW YORK PATHOLOGICAL SOCIETY.

A STATED meeting was held December 24, 1884, John A. Wyeth, M.D., Chairman *pro tem.*

Dr. R. Van Santvoord presented specimens removed from three different patients. The first illustrated

DIPHTHERITIC CROUP.

The child from whom it had been obtained was 13 months old, an inmate of the Randall's Island Hospital. It had been suffering for about a month with diarrhœa, and was said to have had bronchitis. The house physician's attention had not been specially directed to the lungs until last night, when the nurse said the child had been ailing more than usual for some hours, and was in a somewhat stupid condition. The physician

found the patient breathing with difficulty, and examination of the throat revealed a patch on the right tonsil. Death occurred, as nearly as could be estimated, within twenty-four hours of the inception of the throat-trouble.

At the autopsy, membrane was found upon the right tonsil, epiglottis, larynx, and halfway down the trachea. The membrane was loose in the trachea. The trachea and bronchi were injected, and were coated with a copious secretion of muco-pus. About one-third of both lower lobes and about one-half of both upper lobes of the lungs were hepatized from catarrhal pneumonia. The solitary follicles in the intestines were enlarged.

PERICARDITIS, PLEURISY, PNEUMONIA.

The second case was that of a man who had entered the surgical wards of the hospital with varicose veins of the leg. About two weeks before his death he complained of pain over the pericardium, and shortness of breath, and afterwards manifested a certain amount of cyanosis. When Dr. Van Santvoord saw the patient, the heart was beating rapidly and forcibly, the apex-beat was in the nipple-line, but there were no auscultatory deviations, except that subcrepitant râles were heard over the lower lobes of both lungs behind. The patient was slightly cyanotic. Within forty-eight hours bronchial breathing was heard over the left lower lobe. Dr. Maxwell examined the heart several times, and found nothing abnormal other than that the area of dulness extended beyond the impulse of the apex, which was in the nipple-line. There were fine râles over the greater portion of the chest most of the time during the two weeks preceding death.

At the autopsy, the arachnoid membrane showed opacity; there was a certain amount of œdema of the membranes and excess of fluid in the cerebral cavities. More than a pint of fluid was found in the left pleura. The lower lobe of the left lung was compressed, the upper in a condition of gray hepatization, commencing to resolve, the entire lobe œdematous; the right upper lobe was in a condition of red hepatization, and the middle and lower portions in a less advanced stage of inflammation. The pericardium contained blood-stained fluid and had a coating of lymph. There was slight fatty degeneration of the cardiac walls; the left ventricular opening admitted three fingers, the right four. The spleen was shrunken; the kidneys showed a moderate amount of interstitial nephritis.

The case was chiefly interesting as illustrating how easily marked lesions might be overlooked by so competent a diagnostician as Dr. Maxwell.

BRONCHO-PNEUMONIA WITH PLEURISY.

The third specimen was removed from a child about a year old, in whose case no diagnosis had been made by the physician. It illustrated broncho-pneumonia and pleurisy of the right side.

PROLAPSUS OF THE RECTUM.

The fourth specimen was removed from the body of a child which died, aged 19 months, from broncho-pneumonia. The specimen showed prolapsus of the rectum, the peritoneum having also been dragged down to a very considerable extent with the gut. There had been diarrhœa.

Dr. J. C. RIPLEY asked Dr. Van Santvoord if he would relate to the Society what he had previously stated to him in connection with the first specimen.

Dr. VAN SANTVOORD referred to a paper read at a recent meeting of the Academy of Medicine, in which the author, Dr. Winters, took the ground that laryngeal obstruction produced congestion of the lungs, with subsequent pneumonia. Dr. Ripley, on the other hand, claimed that when entrance of air into the lungs was partially obstructed in any portion of the tubular system of the air-passages, instead of having congestion we would have emphysema and consequent anæmia. Dr. Ripley's view was, the speaker said, the one which was accepted by pathologists generally. Dr. Van Santvoord thought that all who had examined the bodies of many children dead from obstruction to the air-passages must have found that emphysema was the usual condition present, and that broncho-pneumonia was exceptional. Consequently the idea of preventing the occurrence of broncho-pneumonia was not an indication for tracheotomy in laryngeal stenosis. He thought this fact was illustrated by the specimen presented, and said the condition of broncho-pneumonia which was present was antecedent to diphtheria.

Dr. RIPLEY did not wish to enter upon the discussion of this subject again at present, but would say that he had recently examined the lungs of a child which had died from croup after tracheotomy, and there was not the slightest indication of pneumonia; the lungs were anæmic and bulged out when the chest was opened.

TRACHEOTOMY FOR DIPHTHERITIC CROUP.

Dr. CHAPIN presented the trachea and lungs of a child, aged 3 years, and gave the following history. It had been ailing with a bronchitis for eight or ten days, when a diphtheritic membrane developed over both tonsils back of the soft palate, apparently extending up into the posterior nares. There was some hoarseness pertaining to the cough, and general bronchitis. Within forty-eight hours dyspnœa developed to an extent that caused considerable recession of the supra- and infra-clavicular and the supra-sternal regions. Within twenty-four hours more it was necessary to perform tracheotomy,—an operation which Dr. Chapin found far from being so

simple and easy to perform as some had recently claimed. Within three-quarters of an hour after the operation the temperature and pulse became considerably more elevated, but subsided again later. A large cast of the trachea was expelled, and the breathing became easy. The next morning the breathing again began to grow difficult, and in the afternoon was as labored as before tracheotomy had been performed. The tube, however, was perfectly clear, and it was evident that the stenosis was lower down in the respiratory tract. At about five o'clock, being called in great haste, as the child was apparently dying, he threw tripsin into the tube by means of the spray, and some pultaceous membrane was expelled, followed by easier respiration. After an hour the breathing was perfectly easy, and, the spray being kept up during the night, the child continued to breathe easily until death took place, the next morning, from blood-poisoning.

At the autopsy very thick membrane existed down to the tracheal wound. Below that point there were bits of membrane which evidently had been partially digested by the pancreatic extract; they extended down to the second division of the bronchial tubes. There were two spots of pneumonia at the bottom of the lower lobe of the right lung.

Dr. J. LEWIS SMITH remarked that in six or eight cases he had used extractum pancreatis mixed with the bicarbonate of sodium as an application to the faucial pseudo-membrane, and certainly in these cases the diphtheritic membrane had disappeared in a much shorter time than it had ordinarily in his practice. The question had once been raised as to whether we should not abstain from doing tracheotomy in cases apparently hopeless, as popular prejudice against the operation would be increased should the patient die. Dr. Smith would not hesitate to operate even if there were only a probability of relieving the child but for a short time.

Dr. WYETH said, with regard to tracheotomy being a very simple operation, that the last time he performed it, which was for a foreign body in the air-passages, it proved very difficult. In that instance the trachea was not in the median line.

Dr. RIPLEY remarked that local applications in his experience seemed to have been failures. He once, however, poured lime-water into the tracheal wound by the teaspoonful, and the result was like that after the use of tripsin in Dr. Chapin's case: the membrane was dissolved, but the child died of diphtheria of the wound. With regard to the temperature running up after tracheotomy, that had also occurred in his practice, but, as a rule, unless the disease progressed, the temperature would fall the next day. Dr. Ripley further said that he thought the apprehension of harm coming from some fluid entering the trachea was unfounded. A teaspoonful of fluid entering the trachea would not reach the air-cells, and if it should, it would do no harm.

Dr. W. P. NORTHRUP said that after the discussion on Dr. Winters's paper at the New York Academy of Medicine, he looked over the records at the New York Foundling Asylum, and found there had been autopsies in sixteen cases of diphtheria with marked laryngeal symptoms. In all these cases the membrane extended down to the finer bronchi, and in one case it extended to within a centimetre of the base of the lung. In reply to a question, Dr. Northrup said he believed there was pretty well marked pneumonia in at least four of the sixteen cases; also that tracheotomy was performed in about four of the cases; but Dr. Dwyre was in the habit of relieving the dyspnœa by a tube inserted between the vocal cords, so that in about twelve of the cases the laryngeal stenosis was entirely relieved.

Dr. A. JACOBI called attention to the fact that the pseudo-membrane in the bronchi and trachea was more likely to macerate than in any other locality. For this reason he believed there were many reports of success following the use of lime-water, alkaline waters, extractum pancreatis, etc. He further said children died from stenosis sometimes after tracheotomy, but not as frequently as when the operation was not performed. The stenosis, moreover, was of a different kind from laryngeal stenosis. It was true there was recession of the supra- and infra-clavicular and of the diaphragmatic regions, but not to the same degree as in laryngeal stenosis. Again, in laryngeal stenosis the respiration was long-drawn and slow, whereas in stenosis due to descent of the croupous membrane the respiration was shorter, more frequent, and resembling more the respirations in pneumonia and bronchitis. In a case presenting the latter form of respiration, the condition should not be regarded as one of pure and uncomplicated croup, but as one of croup with a mixture of inflammatory element, which was liable to cause death from pulmonary congestion, bronchitis, œdema, etc. This was a useful point in diagnosis and prognosis.

Dr. RIPLEY asked Dr. Jacobi if he wished to give the impression that in laryngeal stenosis the respirations were slow.

Dr. JACOBI said yes.

Dr. RIPLEY said he had records of a hundred cases in which the number of respirations per minute were noted, and they were invariably hurried. That was not only true in croup, but it was also true in asthma. The respirations, it was true, were a little different after tracheotomy had been performed and where there was secondary croup, but he thought it was not due to any inflammatory process, but in part to the obstruction being distributed more generally over the lungs,

and more particularly to the fact that the child by this time had become exhausted, the respirations were more shallow, and the dyspnœa was not so noticeable.

Dr. JACOBI thought the statement which he had made, based on observation of several hundred cases of croup, was also supported by theory. For example, a bottle capable of holding a certain amount of liquid would require a longer time to fill if the mouth were obstructed than if it were large and fully open. In laryngeal stenosis there would be no advantage for the child to voluntarily shut off one inspiration when the lungs were only partially filled with air and gasp for more breath. The obstruction to the ingress of the air would necessarily give rise to a longer inspiration to distend the lungs.

DIFFERENTIAL DIAGNOSIS BETWEEN PLEURISY WITH EFFUSION AND PNEUMONIC CONSOLIDATION IN CHILDREN.

Dr. J. LEWIS SMITH related the following history of a case, of which Dr. Northrup gave the result of the post-mortem examination. The child was 11 months old, and for two months had had pertussis, and for ten days preceding the 24th of the month, when he first saw the patient, had been suffering from increased bronchitis. In addition to this, Dr. Smith found, on the 24th, flat percussion-sound on the right side of the chest, except anteriorly, where dulness was not so great. His diagnosis was pleurisy, but, as the house-physician was unable to withdraw any fluid with the aspirator-needle, it seemed necessary to regard the case as one of the many in which it was difficult to differentiate between pleurisy and pneumonia in children. The physical signs, or signs obtained by auscultation and inspection, were often so nearly alike in pneumonia and pleurisy with effusion in children under fifteen months of age, that it was impossible to make a positive diagnosis. In the present instance there was no enlargement of the right side of the chest, nor bulging in the intercostal spaces. He noticed at one point on the right side a little vocal fremitus. The respiration was hurried, the pulse 180 to 190, the temperature 103.5°.

Dr. NORTHRUP said that at the autopsy he found the right lung much more than usually compressed and pushed forward. In the cavity of the pleura was a pint of greenish-yellow fluid, containing pus. Dr. Northrup said he supposed there was a record of seventy-five to a hundred cases of post-mortem examinations in the orphan asylum in which there had been an error of diagnosis between pneumonia and pleurisy in children.

Dr. JOHN A. WYETH presented four specimens illustrating surgery of the jaw.

SARCOMA OF THE INFERIOR MAXILLA.

The first specimen was of interest from a pathological point of view, being a portion of the lower jaw removed for sarcoma in a child 8 years of age. The portion removed extended from the second incisor to the last molar.

The second specimen illustrated the fact that operations performed early for ostitis of the lower jaw were less simple than if done later, after separation of the sequestrum. The third specimen had a history similar to the second, being likewise removed from the left lower jaw, the seat of necrosis.

The fourth specimen consisted of a portion of the left lower maxilla and dental nerve, which had been removed from a patient who had suffered for eleven years from tic douloureux of a severe type. After cutting down upon the nerve, he removed three-quarters of an inch of it and stretched the central portion. The patient had had no pain since the operation.

Dr. WYETH, in reply to a question by Dr. Jacobi, said the sarcoma in the first case had been developing, as he was told, for six or eight weeks.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, September 11, 1884.

The President, JAMES TYSON, M.D., in the chair.

DR. J. M. BARTON presented a specimen of *cystic papillary adenoma of the neck*, which he had removed from a patient at his clinic at Jefferson Medical College on September 6. The patient was a married woman, 31 years of age, the mother of three children. The tumor was of slow growth, having existed for five years, and having increased but little in the last two years. It gave no pain and but little deformity. It was about the size of a walnut, and lay beneath the clavicular extremity of the left sterno-cleido-mastoid muscle, in close proximity to both the subclavian and carotid arteries, from which it received a decided pulsation; on strongly pressing the tumor upwards and outwards, the pulsation ceased. The tumor was closely adherent to a number of large veins of new formation, which greatly increased the difficulties of its removal.

On section, it presents a number of alveoli, of variable diameter, communicating with each other and lined with a thick membrane, similar in appearance to the inner coats of the arteries. This membrane seems to have undergone calcareous degeneration in some portions. When the tumor was fresh, these cysts, on incision, were filled with a dark-red fluid like disintegrated blood.

Report of the Committee on Morbid Growths.—"A section made from the tumor of the neck presented by Dr. J. M. Barton shows a stroma of fibrous tissue, in which cavities are

seen, varying in size, lined with an epithelium having a cuboidal shape. From the margins of many of these cavities papillary ingrowths were noted, covered with cylindrical-shaped epithelium; other cavities are filled with the remains of cells or a structureless, colloid-like substance. The tumor may, therefore, be considered a cystic papillary adenoma, in which a colloid degeneration has occurred, or, from its location, it is not improbable that it may be either an outgrowth from, or a supernumerary, thyroid gland."

PHILADELPHIA NEUROLOGICAL SOCIETY.

THE regular stated meeting was held November 24, 1884, the President, Dr. S. WEIR MITCHELL, in the chair.

Dr. MITCHELL asked Dr. Woodnut, resident physician in the Philadelphia Orthopædic Hospital and Infirmary for Nervous Diseases, to read the notes of a case of erythromelalgia which had been under Dr. Mitchell's care in the hospital.

A CASE OF ERYTHROMELALGIA.

J. C. R., æt. 53, married, blacksmith, family history good. Mother died at 72; father still living. Six sisters still living and healthy; two died young. Has three children, all healthy. Has had scarlet fever, and at 20 variola, which left him slightly hard of hearing. Otherwise always perfectly well until September, 1881, when he first noticed pain on inner side of second toe of the left foot. One year after the third toe was affected, later the little, then the fourth, and about four months ago the great toe,—all on the same side. They were all affected in the same manner,—first a burning, then an aching, pain, and some weeks after there would be discoloration of more or less of the toe. Great toe has been least affected of left foot, only feeling sore at tarso-metatarsal joint.

One year ago the pain began in the right foot, first appearing, as in the left foot, in the second toe. Now it affects second, third, and fourth toes, but not so badly as in the other foot.

Pain is not noticeably worse in wet or cold weather. It is worse at night when the feet get warm. The last seven months, however, this was not so marked. Has occasionally had twitchings, chiefly at night, in calf of left leg and bottom of left foot. About six years ago the arms began to ache at night, and do occasionally yet. Pain is confined (to muscles apparently) just above the elbows. Arms are not quite so strong as formerly, but attributes it to want of use. Nine years ago ran a harrow-tooth in outer side of bottom of left foot. It healed without difficulty and left no apparent after-symptoms.

In January, 1883, had second toe of left foot amputated at proximal joint. It healed slowly, but relieved the pain not only in that toe, but also in the others.

The surgeon who removed the toe said that the amputated portion was "turned to gristle, and had no circulation."

Has no history of syphilis nor alcoholism.

At present all the toes affected are discolored. The left foot, up to the ankle, is covered irregularly with reddish patches, sometimes dark and sometimes brighter, disappearing on pressure, and more or less sensitive. Little discoloration on right foot except at corners of nails, and the disease has not developed so rapidly in the right as in the left foot.

Foot more or less swollen to the ankle. "Tendons seem sore." Occasionally pain in outer left ankle. Occasionally whole leg aches, but greater pain is on the spots of redness.

Pain, on walking, in the ankle and in the bottom of foot, so can only walk two or three blocks. Within the past few weeks a number of patches have appeared on the left leg, and one on the spine about the middle of dorsal region. For six or seven years has had occasional pains down the spine. It probably comes from a former sprain.

Also occasional sharp shooting pains at back of neck, on each side of spine, and down towards the shoulders, in the direction of brachial plexus. Not tender on pressure.

Sensation slightly diminished in the whole left limb, except on the patches of redness, where it is increased.

Elec. condition. No De R. Response equal in both legs to Galv. c. Far. c., slightly diminished action in left leg below knee. Sensation to both currents lessened in left limb. Measurement: r. calf, 13⅛; l., 12½; r. thigh, 20⅜; l., 20½.

Temp. R. 92⅘, L. 93⅕.

Dyn. R. 71, L. 70.

Appetite good, and, excepting pain, feels as well as ever. Urine, sp. g. 1.027; no albumen nor sugar.

His treatment has been absolute rest, massage, descending stabile galvanic current, and hot and cold applications to the spine once a day, chloride of gold and sodium. Fowler's solution and ergot have also been used.

11.21. An irregular-shaped patch appeared on dorsum of each wrist, preceded for forty-eight hours by pain and soreness; disappeared after being out thirty-six hours.

11.23. Redness appeared on each arm above elbow. Not preceded by pain, and appearing just after massage. Massage also brings it to view more plainly in the leg.

After the reading of the notes Dr. Mitchell brought the case before the Society.

Dr. CHARLES K. MILLS said he had seen quite a number of similar cases. His belief was that some at least of these cases were spinal in origin. The fact that some get well

is not against this theory. A few years ago he had attended a lady who had all the symptoms of diffused myelitis from unknown cause. He had also studied several cases of arsenical paralysis due to diffused myelitis. When the feet were pendent, in these cases, they would become hot, red in color, etc., like some of the cases of erythromelalgia. Dr. McBride, of New York, has described another type of cases, in which the limb is diminished in size, is cold, blue, etc.

Dr. MITCHELL said that he had no doubt that some of the cases of erythromelalgia were spinal in origin. He was not so certain, though, as to the spinal condition. In some of the cases an hysterical condition is present.

ON THE DIETETIC FACTOR IN THE TREATMENT OF ANGINA PECTORIS.* BY N. A. RANDOLPH, M.D.

There has recently been under my care a patient suffering from true angina, in whom, as is not seldom the case, any slight gastric irritation constituted the immediate exciting cause of the frequently-recurrent paroxysms.

After the last attack there existed an inability to retain the lightest and simplest foods, their ingestion inducing not only nausea, but much cardiac distress. Recourse was had, with advantage, to milk partially digested by the commercial Extractum Pancreatis, but the flavor of the resultant preparation was unappetizing, and finally became repulsive to the patient, who whimsically described its taste as that of "stewed corpse."

To meet this emergency there were devised two food-products, which I have not seen described, and which, in practice, proved eminently satisfactory.

I. *Pancreatized Oysters.*—The oysters of an ordinary stew (containing milk) are removed and finely minced, then returned to the liquid portion of the stew. The whole is brought to a temperature of 100° Fahr., the appropriate proportions of pancreatic extract and sodium bicarbonate are added, and the mixture maintained at the temperature mentioned for thirty minutes, with occasional stirring. It is then strained and served, and forms not only a highly nutritious and palatable soup, but one which is retained by very irritable stomachs, and utilized with a minimum of digestive power. After boiling, to prevent the further action of the digestive ferment, gelatin may be added, and the mixture served cold as a jelly. Cooked tomato, onion, celery, or other flavoring suited to the individual taste of the patient, may be added at the beginning of the artificial digestion, and the solid residue removed in the final process of straining, at which time it will be noticed that the minced oysters originally added have been in great part dissolved.

II. *Pancreatized Milk-Toast.*—Ordinary milk-toast, in which there is an abundance of milk, when digested in the manner just described becomes an almost homogeneous pulpy mass, which, when the crusts have been removed, is usually acceptably retained by the irritable stomach. In extreme cases, however, it may advantageously be strained and the fluid portion alone used, in which the partially-peptonized solution of casein of the milk is reinforced by actually-digested gluten and starch of the bread, together with a very little dextrin. Plain light sponge-cake may be similarly digested, and occasionally forms a desirable change.

In conclusion, I would express the hope that these rather homely suggestions may prove of value in other hands in extending the somewhat scanty bill of fare suited to patients suffering from gastric hyperæsthesia, and the various neurotic troubles of which such a condition may be the exciting cause.

* Read at the October meeting.

Dr. G. BETTON MASSEY made a few remarks on

THE POLARITY OF CURRENTS OF MEDICAL COILS.

He called the attention of the Society to a singular omission made by the authors of most books on electro-therapeutics. After stating in the introductions that induced currents were to-and-fro, with constantly-changing polarity, they subsequently refer to these as having a fixed polarity, and make no explanation of this seeming impossibility. It is a fact readily tested by any one, that these coils furnish a current of one direction (the direct induced) at the opening of the battery circuit and none at the closure. As it is difficult to close the battery circuit by hand in these batteries without an irregular opening occurring at the same time, the currents due to this "raggedness" of the contact have been mistaken by some for inverse currents induced by the closure. Care, however, will eliminate this source of error, and prove that only currents produced in both primary and secondary coils at opening of the battery current are strong enough to be perceived by the senses. In the primary coil, whatever induction occurs at the closure, of course, goes through the cell as the short route. In the secondary coil this closure-current is supposed to be inhibited by the simultaneously-formed extra current of the primary coil. At any rate, it is not strong enough to be perceptible, and all currents therefore have a genuine polarity in our faradic batteries.

Dr. LLOYD said that he did not think that Dr. Massey was quite just in his criticism on modern writers, as Erb and one or two others mentioned the facts in their works.

Dr. MASSEY said he was misunderstood, as he had said that *most* writers did not allude to it.

TEMPERATURE RECORD OF EACH SIDE OF THE BODY IN A CASE OF HEMIPLEGIA.

Dr. W. SINKLER said he wished to call the

attention of the Society to a temperature record which he observed in a case of hemiplegia. He said from the beginning to the end of the seizure the temperature on the affected side was from one-fifth to one degree higher than on the other side.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, THURSDAY, OCTOBER 2, 1884.

The President, R. A. CLEEMANN, M.D., in the chair.

DR. WILLIAM GOODELL read a paper on

RAPID DILATATION OF THE UTERINE CANAL.

(See page 265.)

Dr. HARRIS inquired about the danger of lighting up a former ovaritis by dilatation. The operation is successful, but that is its danger.

Dr. GOODELL said that he does not hesitate to operate, but always uses opium first, so that by the time the operation is over the patient is under its influence. He keeps them in bed and under the opium until tenderness has passed entirely away.

Dr. WILLIAM GOODELL exhibited a

DERMOID CYST OF THE RIGHT OVARY.

A saleswoman, aged 27, was obliged to give up her situation because she found herself unable to stand for any length of time. Her physician discovered a pelvic tumor, and called in Dr. Goodell to see her. The diagnosis was obscure, but he leaned to a fibroid degeneration of the right ovary. The woman was otherwise well, suffering no pain whatever, except when she was in the upright position. The operation was performed on September 8, and the tumor turned out to be a dermoid cyst. Being enveloped in the broad ligament, it was removed with difficulty. It is stuffed with hair and contained a plate of bone, the sharp edge of which was readily felt per vaginam; but it threw no light on the diagnosis, as it was mistaken for a fibroid spur. His patient did uniformly well, and is now out of bed. He stated that in his experience these tumors are very vulnerable, and often resent even so slight an operation as aspiration, inflammation and suppuration quickly setting in. A physician had to-day brought to his office a young woman who had been tapped last June with a trocar. Long hairs and much sebaceous matter escaped through the opening, which had not yet healed up, and it was for this reason that he had been consulted. Upon passing in a uterine sound, he struck a foreign body, which, from its density and the sharp click it gave, he was disposed to think was a tooth. He advised dilatation of the fistulous track and the removal of the offending body.

TWO CASES OF ÖOPHORECTOMY.

Dr. GOODELL also exhibited the ovaries which he had removed on September 17 and 29 from two patients, who now were doing well. He stated that the amount of tissue-change in these ovaries was very slight, and yet the suffering of each patient had been great. One had been an invalid for several years and bedridden for the past six months. She had lost much flesh, and was always groaning from left ovarian pain unless under the influence of large doses of morphia administered hypodermically. The left ovary was found to be undergoing cystic degeneration, but the right one was so sound that in its removal he was glad to have the backing of Prof. W. S. Playfair, of London, who was present at the operation. For he believed that in most cases needing öophorectomy the results usually showed failures unless both ovaries were removed and the menopause established. Convalescence after the operation had been retarded by great and painful swelling of both parotid glands, which developed without any marked rise in the temperature and without acceleration of pulse, and declined without suppuration,—behaving exactly like mumps. This made his third case of parotitis following the removal of the ovaries. Not one had ended fatally, and from the very slight febrile movement he thought that the complication was not symptomatic, as in blood-poisoning, but sympathetic, and that a strong kinship, recognized by laymen, existed between the sexual organs and the cervical glands. Since the operation all pelvic pain had ceased.

The other patient was a poor woman, aged 30, the mother of seven children. She was sent to him by Dr. George S. Hull, of Chambersburg, Pa. Three years ago she began to suffer from double ovaralgia. The pain never left her wholly, but it began to increase in severity a week before the period, culminated during the flux, and faded off afterwards. Large doses of anodynes were also needed in this case, and she was unable to work. The case was clearly one of ovarian dysmenorrhœa, and he believed that she would be permanently cured.

BACILLI IN SYPHILIS.—The discovery of bacilli in syphilitic lesions is announced by Dr. Lustgarten (*Wien. Med. Wochensch.*, No. 47). His researches, which were made in Weigert's laboratory at Leipsic, consisted in a special method of preparation and staining of sections of primary chancres and a gumma. In all were found, isolated or in small groups, slender, straight, or slightly-curved bacilli, much resembling tubercle-bacilli. The organisms were embedded within swollen lymphoid cells, and exhibited transparent spots, which resembled the "spores" of Koch's tubercle-bacillus.—*Lancet.*

REVIEWS AND BOOK NOTICES.

THE PHYSICIAN'S DAILY POCKET-RECORD. Comprising a Visiting-List, many useful Memoranda, Tables, etc., by S. W. BUTLER, M.D. Nineteenth year. New and thoroughly-revised stereotype edition, with Metric Posological Table, etc. Edited by D. G. BRINTON, M.D. Philadelphia, 1885. Patent flap.

This is a standard visiting-list, well known and generally liked by those who keep a pocket-record: it is substantially bound, with a self-acting clasp, contains good paper, and satisfactorily answers its purpose.

THE PHYSICIAN'S VISITING-LIST (LINDSAY & BLAKISTON'S) FOR 1885. Thirty-fourth year of publication. Philadelphia, P. Blakiston & Co.

Blakiston's Visiting-List for 1885, with the tuck-flap, is an old favorite with many members of the profession. It is a little smaller in size than the preceding, but contains the usual lists of new remedies, poisons and antidotes, and posological table, and is a good, practical pocket-record.

THE PHYSICIAN'S COMBINED DAY-BOOK AND LEDGER. By H. T. HANKS, M.D., New York. For sale by J. H. Vail & Co., New York. Half-Russia back and corners, and cloth sides. For 2200 accounts, $4.50; 3700 accounts, $5.50.

Those who do not use a pocket visiting-list will find in the Combined Day-Book and Ledger a system of book-keeping well worth examination. It is claimed that in its facilities for keeping the accounts legibly and correctly with the least possible expenditure of time and labor this method is superior to all others that have ever been devised. From careful examination, it appears that this system of book-keeping has many and decided advantages to commend it to the attention of the busy physician, who will find by its aid that the labor of keeping his accounts is reduced to a minimum.

HENKE'S ATLAS OF SURGICAL ANATOMY. A Series of Plates illustrating the Application of Anatomy to Medicine and Surgery. Translated and edited by W. A. ROTHACKER, M.D., Pathologist to the Cincinnati Hospital, Lecturer on Pathological Anatomy in Miami Medical College. Cincinnati, A. E. Wilde & Co., 1884. Bound in half-morocco, $10.

The translator and publishers have rendered a real service in placing in such accessible and acceptable form the well-known Topographical Anatomy of Henke: it is a clear, plain exposition of applied anatomy for everyday use. To the student, surgeon, and physician these plates are useful, showing the various organs and structures in their natural relations, thus refreshing the mind and reviving the lessons learned in the dissecting-room and operative surgery class.

There are eighty-one full-page plates, printed on heavy toned paper, with abundant explanatory references upon each diagram. For the most part the figures are well drawn and distinctly printed, and include representations of the principal organs of the body, seen *in situ* and in section. The value of this work is self-evident, and its execution deserves the highest commendation.

THE MEDICAL RECORD VISITING-LIST, OR PHYSICIAN'S DIARY FOR 1885. New York, William Wood & Co.

This is the *édition de luxe* of visiting-lists, having gilt edges, Russia binding, and large flap, and is probably the favorite for New-Year's gifts to physicians.

GLEANINGS FROM EXCHANGES.

GASTRITIS FAVOSA: A NEW DISEASE.—At the meeting of the Vienna Imperial and Royal Society of Physicians on the 28th of November, Prof. Kundrat exhibited specimens of a unique kind. The case was one of favus universalis which had given rise to an abscess of the thigh, and had terminated fatally from severe gastro-intestinal disorder marked by an uncontrollable diarrhœa. Numerous erosions mingled with diphtheritic swellings were found in the mucous membrane of the stomach, and the intestines contained some foul putrescent masses and much mucus. Prof. Kundrat at once declared the diphtheritic swellings to be due to the favus fungus,—a view which was confirmed on microscopic examination. This is the first recorded instance in which the mucorineæ have been the cause of death, as it is the first of favus of the stomach and intestines. Indeed, the naked-eye appearance of the tumors in the stomach closely resembled the favus cups on the skin, and the fact that but little of the fungus was found in the intestine was explained by Prof. Kaposi by their having undergone putrefaction in the bowel. The patient had previously been shown to the Society by Prof. Kaposi as a rare instance of favus, which covered the entire body, affecting even the finger-nails (attributed to his habit of scratching himself constantly). Favus of the stomach is as unknown a condition in animals as it is in man; at any rate, Prof. Csoker, of the Vienna Hospital for Animals, stated that it never occurred in cats, although these animals frequently eat rats infested with the fungus. Prof. Bamberger suggested that in this case the gastric mucosa was in an unhealthy condition at the time of infection, thereby affording a favorable nidus for the growth of

the fungus. It must be borne in mind that the mucorineæ, unlike the schizomycetes, can thrive in acid liquids, and may therefore grow with impunity in the stomach. The case is of great importance, as showing that, if they do gain access to the interior of the body, these fungi may be a source of danger and lead to a fatal result, thereby disproving the usually-accepted notion of their harmless character.—*Lancet.*

THALLIN.—The industry of Continental chemists in the application of the synthetical methods to the formation of new compounds has brought to light a new antipyretic agent, which appears to have been used successfully in a large number of cases in the clinic of Prof. Nothnagel. It has the constitution of a secondary chinoline base, being one of a number of chinoline derivatives prepared by Prof. Skraup, and is represented by the systemic name, "Tetrahydroparachinanisol." The salts of this base, which have an acid reaction, are freely soluble in water, and have the property of forming green compounds when treated with solution of ferric chloride and oxidizing agents. On account of this peculiarity, the cumbrous systemic name has been dropped in favor of the shorter designation, "thallin." The hydrochlorate, sulphate, and tartrate of thallin and the hydrochlorate of ethyl thallin are the salts that have been employed, and these are said to show great antipyretic activity in doses of quarter, half, and three-quarters of a gramme, —a point in which thallin would seem to compare favorably with some of its competitors. The lowering of the temperature is said to take place gradually and to last a considerable time, whilst it is not accompanied by any secondary disturbances. Thallin can be conveniently administered in wafers containing a quarter or half of a gramme of the sulphate. Two other chinoline derivatives have been experimented with; one of them has but slight antipyretic properties, whilst the other was fatal to guinea-pigs in doses of from .2 to .6 gramme, violent tetanic seizures being excited.—*Lancet.*

ALKALOIDS OF QUEBRACHO.—For a long period of time the inhabitants of South America have employed quebracho on account of its febrifuge, tonic, antiasthmatic, and astringent properties. White quebracho, of which three species are recognized, is a tree belonging to the family of Apocynæ, which abounds in the Argentine Republic. Penzoldt in 1879 proved that a decoction of the bark slowed the pulse and diminished the frequency of respiration, but he noted no antipyretic effects. Berthold and Picot confirmed these results. The value of one of the alkaloids, aspidospermine, discovered by Fraude, in relieving dyspnœa has been corroborated by a number of independent observers. Hesse has determined that there are as many as six alkaloids in the aspidospermine of commerce. MM. Eloy and Huchard have separated the alkaloids in a state of purity, and have made a series of thirty-six physiological experiments in reference to their antithermic action. The experiments were made on rabbits, guinea-pigs, and dogs, by means of subcutaneous injections. All the alkaloids were found to exercise a marked antipyretic action. A remarkable effect was also observed to occur in the color of the venous blood, which became of a vermilion-red tint like that seen after poisoning by prussic acid and carbon monoxide. Subcutaneous injections of from .10 to .20 centigramme of the hydrochlorate of aspidospermine, in patients suffering from typhoid fever, appeared to lower the temperature in cases where quinine had had no effect. Lactate of aspidospermatine is a more powerful alkaloid in reducing the temperature than hydrochlorate of aspidospermine; the sulphate of hypoquebrachine and the lactate of quebrachine are still weaker antipyretics.—*Lancet.*

THE ETIOLOGY OF TRICHORRHEXIS NODOSA.—In opposition to the opinion of Eichhorst, who has recently written upon this condition, Dr. Wolffburg states that the sole cause of trichorrhexis nodosa is the improper care of the hair. He showed in his own person that it could be produced in the beard on one side by rubbing it energetically and frequently, the other side meanwhile being normal. The following are the grounds upon which the author bases his belief in the mechanical causation of trichorrhexis (*Centralblatt für Klinische Medicin*, No. 38, 1884): 1. The anatomical appearances,—the hair, except for the nodules, is healthy. 2. The localization,—the affection has hitherto been observed only in the larger hairs of the beard, and especially in those so situated as to be most exposed to mechanical injury when the face is rubbed, as in the beard covering the lower jaw. 3. The explanations hitherto offered are insufficient. 4. The supposed incurability of the affection is easily explained when one remembers that the treatment usually recommended (frictions with alcoholic preparations or irritating salves) only furnished new sources of irritation to the ill-treated beard.—*Medical Record.*

THE CONTAGIOUSNESS OF INEBRIETY.—The climax of absurdity in regard to inebriety appears to have been reached. In a recent number of the *Alienist and Neurologist*, Dr. Crothers, assuming that inebriety is a disease, classifies it among contagious disorders, and ventures to illustrate his conclusion by the citation of cases, and pretends to trace its analogy to measles and other zymotics, but he omits to take note of the difference in their environments. — *Sanitarian.*
[If this be true, what a field it opens for preventive inoculation!—ED. P. M. T.]

IRRITABLE SPINE AND SPINAL MYALGIA.—In a lecture (*The Practitioner*) upon this subject, Dr. S. J. Gee says that the disorder is a real one and not hysterical, although it may be associated with hysteria. Although the patient often exaggerates her symptoms, it cannot be regarded as imposture, because it is unintentional and has underlying it a genuine disorder. Irritable spine means simply painful spine, either neuralgic or myalgic. In regard to treatment, as the patients are generally poorly fed, it is necessary in the first place to see that they take food enough, that it is of good quality, and that it is given sufficiently often. A moderate allowance of alcohol in the form of stout, ale, or wine may be reckoned as part of the food. The muscles must be well nourished, or the treatment will do little good.

Secondly, the muscles must be rested. The pain is of the nature of fatigue. The muscles of the neck and back cannot be rested unless the spine be supported in its whole length; the patient must lie on a couch or recline in a very easy chair with a long, high back, and with elbows, so that the weight of the arms is taken off the spine. Yet here also is a difficulty. A prudent man thinks twice, or a dozen times, before he condemns a young woman to the sofa. There is danger that she will never rise from it, and will be a burden to herself and all her friends and relatives for the rest of her life. Beware of insisting too much upon the repose of the couch: it were sometimes far better that they should continue to complain of their pains. In this dilemma the best advice I can give you is that you should recommend a certain amount of reclining, and carefully watch lest your patient show signs of becoming a slave to the sloth of the sofa. With the better sort of women there is little fear of this: they prefer an irritable spine to laziness.

Another means of resting the muscles which perhaps occurs to you is well-fitting stays. But on second thoughts you will see that stays do not come high enough to support the head and shoulders; and it is here that spinal myalgia most commonly shows itself.

Local applications to the spine, more or less anodyne, are useful. Warmth, for instance. Our patient declared she was much relieved by a douche of hot water to the spine. Belladonna liniments are useful.

Lastly, I think that patients who have once developed an irritable spine seldom altogether lose it, or at least they will seldom confess that they are altogether free from pain in the back.

CONVULSIONS CAUSED BY CONSTIPATION.—Dr. J. F. Baldwin, in the *Columbus Medical Journal*, reports the case of a lady 67 years of age, though apparently much older, whom he found in a general convulsion. The eyes were turned up, the eyelids half open and twitching, the limbs jerking about and with a slight tendency to opisthotonus. On extending the arms at right angles to the body, they would remain rigid, as in catalepsy, except some fibrillary twitching, for some minutes, when they would gradually, and with increased twitching, sink to the sides. She was entirely unconscious, and could not be aroused. She had been in this condition for three hours. Two hours later, after several large doses of potassium bromide, she returned to consciousness, and said that she felt as well as usual. She had taken salts the night before, which had operated freely. The urine was normal. The next day her convulsions returned, and recurred daily for the next two weeks. A full dose of croton oil was administered, which operated freely. Antispasmodics, quinine, and purgatives failed to relieve her condition, and she was manifestly growing weaker. Upon making a digital examination, the uterus was found in good position, but an impaction of fæces as large as a child's head was discovered in the rectum, notwithstanding the purgatives had acted freely. The mass was removed, and the patient at once recovered.

MISCELLANY.

THE NINTH INTERNATIONAL MEDICAL CONGRESS, TO BE HELD IN WASHINGTON, D.C., IN 1887.—The Committee on Organization of the Ninth International Medical Congress met in Washington, D.C., on November 29, 1884, for organization.

The following rules were adopted:

1. The Congress will be composed of members of the regular medical profession who shall have inscribed their names on the register of the Congress and shall have taken out their tickets of admission. As regards foreign members, the above conditions are the only ones which it seems at present expedient to impose.

The American members of the Congress shall be appointed by the American Medical Association, by regularly organized State and local medical societies, and also by such general organizations relating to special departments and purposes as the American Academy of Medicine, the American Surgical Association, the American Gynæcological, Ophthalmological, Otological, Laryngological, Neurological, and Dermatological Societies, and the American Public Health Association; each of the foregoing Societies being entitled to appoint one delegate for every ten of their membership.

The members of all special and subordinate committees appointed by the General Committee shall also be entitled to membership in the Congress, together with such other persons as may be specially designated by the Executive Committee.

All Societies entitled to representation are requested to elect their delegates at their last regular meeting preceding the meeting of the Congress, and to furnish the Secretary-General with a certified list of the delegates so appointed.

2. The work of the Congress is divided into eighteen sections, viz.: 1. Medical Education, Legislation, and Registration, including methods of teaching, and buildings, apparatus, etc., connected therewith. 2. Anatomy. 3. Physiology. 4. Pathology. 5. Medicine. 6. Surgery. 7. Obstetrics. 8. Gynæcology. 9. Ophthalmology. 10. Otology. 11. Dermatology and Syphilis. 12. Nervous Diseases and Psychiatry. 13. Laryngology. 14. Public and International Hygiene. 15. Collective Investigation, Nomenclature, and Vital Statistics. 16. Military and Naval Surgery and Medicine. 17. Experimental Therapeutics and Pharmacology. 18. Diseases of Children.

3. The General Meetings will be reserved for the transaction of the general business of the Congress and for addresses or communications of scientific interest more general than those given in the Sections.

4. Questions which have been agreed upon for discussion in the Sections shall be introduced by members previously nominated by the officers of the Section. The members who open discussions shall present a statement of the conclusions which they have formed as a basis for debate.

5. Notices of papers to be read in any one of the Sections, together with abstracts of the same, must be sent to the Secretary of that Section before April 30, 1887. These abstracts will be regarded as strictly confidential communications, and will not be published until the meeting of the Congress. Papers relating to questions not included in the list of subjects suggested by the officers of the various Sections will be received. Any member, after April 30, wishing to bring forward a subject not upon the programme, must give notice of his intention to the Secretary-General at least twenty-one days before the opening of the Congress. The officers of each Section shall decide as to the acceptance of any communication offered to their Section, and shall fix the time of its presentation. No communication will be received which has been already published, or read before a Society.

6. All addresses and papers, read either at general meetings or in the Sections, are to be immediately handed to the Secretaries. The Executive Committee, after the conclusion of the Congress, shall proceed with the publication of the *Transactions*, and shall have full power to decide which papers shall be published, and whether in whole or in part.

7. The official languages are English, French, and German.

No speaker shall be allowed more than ten minutes, with the exception of readers of papers and those who introduce debates, who may occupy twenty minutes.

8. The rules, programmes, and abstracts of papers will be published in English, French, and German.

Each paper or address will appear in the *Transactions* in the language in which it was delivered by the author. The debates will be printed in English.

9. The officers of the General Committee on Organization are a president, three vice-presidents, a secretary-general, and a treasurer, and those elected to these positions will be nominated by the General Committee to hold the same offices in the Congress. All vacancies in these offices shall be filled by election.

10. There shall be an Executive Committee, to be composed of the President, Secretary-General, and Treasurer of the General Committee, and of four other members, to be elected by the General Committee. The duties of the Executive Committee shall be to carry out the directions of the General Committee, to authorize such expenditures as may be necessary, and to act for the General Committee during the intervals of its sessions, reporting such action at the next meeting of the General Committee.

11. There shall be a Standing Committee on Finance, composed of five members, to be appointed by the President, subject to the approval of the Executive Committee.

12. Those who are elected as chairmen of the several Sections shall be thereby constituted members of the General Committee.

The officers elected are as follows:

President.—Dr. Austin Flint, Sr., of New York.

Vice-Presidents.—Dr. Alfred Stillé, of Philadelphia; Dr. Henry I. Bowditch, of Boston; Dr. R. P. Howard, of Montreal, Canada.

Secretary-General.—Dr. J. S. Billings, U.S. Army.

Treasurer.—Dr. J. M. Browne, U.S. Navy.

The Executive Committee.—The President, the Secretary-General, and the Treasurer (*ex officiis*); Dr. I. Minis Hays, of Philadelphia; Dr. A. Jacobi, of New York; Dr. Christopher Johnston, of Baltimore; Dr. S. C. Busey, of Washington.

RECENT MEDICO-LEGAL NOTES.—A Massachusetts court not long since decided an interesting malpractice case, where the defendant, an irregular medical practitioner, treated a patient by applying, with her consent, flannels saturated with kerosene-oil. Under this treatment she died, and the physician was indicted for manslaughter and convicted. This verdict was appealed from on the ground mainly that, under the Massachusetts law, a person cannot be guilty of manslaughter unless he does some unlawful act, and that there was no law which prohibited any man

from prescribing for another with his consent, if he honestly intends to cure. The defendant also appealed from the judge's ruling that there need be no evil intent, but if, by gross and reckless negligence, the defendant caused the death, he was guilty of culpable homicide.

There seems to have been no question raised on the trial that the so-called doctor had little knowledge of medicine, and this lack of knowledge was asserted in his behalf as a reason for believing that there was no evil intent.

All of the objections raised were overruled by the Appellate Court and the conviction sustained.

A portion of the opinion is as follows: "In dealing with a man who has no special training, the question whether his act would be reckless in a man of ordinary prudence is equivalent with an inquiry into the degree of danger attaching to the act of common experience under the circumstances known to his action. It is here implied, and is undoubtedly true as a general proposition, that a man's liability for his acts is determined by their tendency under the circumstances known to him, and not by their tendency under all the circumstances actually affecting the result, whether known or unknown.

"Another cannot escape on the ground that he has had less than a common experience. Common experience is necessary to a man of ordinary prudence, and a man assuming to act as the defendant did must have it at his peril. Here the defendant knew he was using kerosene. More than that, he saw from day to day how it worked. The jury found that it was applied as a foolhardy presumption or gross negligence, and that is enough.

"When the defendant applied the kerosene to the person deceased in a way which the jury have found to be reckless, or, in other words, seriously and unreasonably endangering life according to common experience, he did an act which his patient could not justify by her consent, and which therefore was an assault, notwithstanding that consent."

In the recent case of Wm. C. Rhinelander in New York, who was charged with a murderous assault upon Mr. John Drake, the family lawyer, and who was alleged by his relatives to be insane, the unfortunate results of the present system of expert evidence were clearly shown. Mr. Rhinelander insisted with the greatest emphasis that he was perfectly sane, but, according to the New York Code of Criminal Procedure, when there is an allegation of insanity this point must be settled before the prisoner is called upon to plead to the indictment. A commission was appointed, which took many hundred pages of testimony, a large number of physicians being called by one side to sustain and by the other to overthrow the charge of insanity. A majority of the commission reported in favor of Rhinelander's insanity, but one of the commissioners said that he was perfectly sane, and this latter opinion was accepted by the court, which declared "that the expert evidence is of no value in this investigation. While the physicians called by the people to sustain the allegation of insanity say that the defendant is insane, they differ radically among themselves as to the classification of that alleged insanity. Two say he has general paresis, one says that he is an imbecile, and another that he suffers from melancholia. He cannot have all these conditions at one and the same time; insanity in its initial stages and in its progressed stages cannot coexist in the same person."

The English Court of Appeal has just decided as a question of law that the killing of the boy Parker by Captain Dudley, of the yacht "Mignonette," was not an act of necessity or self-defence, but murder.

It will be remembered that the yacht was lost in the South Pacific Ocean some months since, and the captain, two sailors, and the boy took to a boat. They were tossed about on the open sea for several weeks, and for nearly three weeks were without food, and for the last five days without water.

Under these circumstances, when the boy seemed to be fast sinking and there was every prospect that all would die, the captain killed the boy, and the survivors sustained life upon his flesh until they were rescued. The fact of the killing was not concealed, and did not appear to be considered criminal by Captain Dudley.

Upon arrival in England he was, however, arrested for murder, and the trial has just been concluded. The jury were charged by Baron Huddelestone, the judge, that the act was not self-defence or necessity, but the jury did not pass upon the criminality of the deed; they simply found the facts and recommended the mercy of the court. The question of law as to what the facts as proven constituted, whether murder or not, was reserved for the Court of Appeal, and this tribunal has just unanimously decided that the act is murder. Sentence of death has been pronounced upon the unfortunate captain, but it is probable that this sentence will be commuted. It hardly seems as if a person without food for nearly three weeks, and for nearly a week without water, is responsible for his acts. The strain under such circumstances upon the brain is awful to contemplate, and might well overpower all resistance of the will. There has never been a similar case in the courts, and the only one at all like it was tried some forty years ago. In that instance passengers were thrown overboard to lighten a boat, and the court decided that seamen not needed for the working of the boat should be sacrificed before the passengers, and that the doomed

men should be chosen by lot. As this was not done, the court held the case to be that of manslaughter.

IMPORTANT TO THOSE WHO USE MALT-EXTRACT.—W. W. Lamb, M.D., Chief Drug-Inspector of the Port of Philadelphia, writes that he has used Johann Hoff's Malt-Extract for the past five years in his private practice, and has found it a health-restoring beverage and tonic nutritive, being especially good for persons convalescing from fever, for cases of dyspepsia, for nursing mothers, and for weakly children, and also in lung-troubles. His attention had been drawn by the immense importation semi-monthly, and he states that about a million bottles imported by Eisner & Mendelson have passed his inspection in the Custom-House during the past five years.

A VALUABLE THERAPEUTIC SUGGESTION.—M. Dujardin-Beaumetz presented to the Société de Thérapeutique siphons of water, lemonade, and white wine, resembling seltzer water, excepting that oxygen replaced carbonic acid. They are recommended for gastric disorder, diabetes insipidus, and loss of appetite.

THE ANNUAL MEETING OF THE COLLEGE OF PHYSICIANS was held Wednesday, January 7, when the following officers were elected: President, J. M. Da Costa, M.D.; Vice-President, S. Weir Mitchell, M.D.; Secretary, Richard A. Cleemann, M.D.; Treasurer, Chas. Stewart Wurts, M.D.; Honorary Librarian, J. H. Hutchinson, M.D.; Recorder, J. Ewing Mears, M.D.

THE PHILADELPHIA COUNTY MEDICAL SOCIETY held its annual meeting on the 7th instant. The following officers were elected: President, R. J. Levis, M.D.; Vice-Presidents, O. H. Allis, M.D., and De Forest Willard, M.D.; Secretary, H. Leffmann, M.D.; Corresponding Secretary, M. S. French, M.D.; Treasurer, L. K. Baldwin, M.D.; Librarian, C. M. Seltzer, M.D.

THE ACADEMY OF SURGERY held a stated meeting on the 7th instant, at the College of Physicians, when Dr. John H. Packard delivered the annual address.

GOLD MEDAL AWARDS TO UNITED STATES PRODUCTS.—Among the food-products exhibited at the International Health Exhibition, London, 1884, from the United States, were beef-peptonoids and maltine. Both of these preparations carried off the only gold medal and highest award against numerous competitors in their respective classes. All food-preparations were critically analyzed at this exhibition by a jury composed of the best chemists in the country.—*London Lancet.*

LONDON LECTURES.—Dr. Osler, of Philadelphia, will deliver the Gulstonian Lectures for 1885 at the College of Physicians; Dr. Herman Weber will deliver the Croonian, and Sir Andrew Clark the Lumleian Lectures.

NOTES AND QUERIES.

MEDICATED TAMPONS IN DISEASES OF WOMEN.

1504 WALNUT STREET, PHILA.

MR. HARRIS, of H. C. Blair's Sons, cor. Eighteenth and Chestnut Streets, has made for me, with great care and skill, some valuable cotton tampons, which I have used in conveying various substances to the vaginal walls and uterus, and also in a measure giving support to the congested and inflamed tissues until they became more tolerant to a pessary. These tampons are made of masses of absorbent cotton, salicylated, borated, carbolized, and thymolated, folded into conical shape, and coated with a preparation which keeps them in form so as to be easily introduced until they come in contact with the heat and moisture of the tissues. To each a string is attached firmly, by which it can be removed. They can be introduced preferably with a speculum if it is necessary to place them in a special position, and I usually dip them for an instant in hot water if the vagina is very dry and inflamed. Otherwise I coat the truncated end of the cone with a small quantity of vaseline, or with the glycerole of tannin or of sanguinaria if these substances are required.

These tampons are also used to convey iodoform to the tissues. Twenty or thirty grains of iodoform are placed in the centre, and after the shape is given to the mass very little odor is perceptible; but the heat of the body at once volatilizes the iodoform and brings it in direct contact with the mucous membrane. These tampons will not become offensive, and can be allowed to remain *in situ* a week or more. This is especially valuable when a number of them are used to correct displacement.

To those who have read Professor Parvin's excellent paper before the Lehigh Valley Society (*Phila. Med. Times*, vol. xv., page 8) the uses of pledgets of soft antiseptic materials in the vagina are well known. They absorb secretions, convey antiseptic and other substances directly to the mucous membranes; they deplete inflamed tissues, separate surfaces which mutual contact irritates, and in certain cases relieve the tension on the uterine ligaments which may themselves be congested or inflamed by supporting the heavy uterus, and thereby allowing medication, both internal and local, to relieve the engorgement and restore tonicity to those tissues and the vagina. Also in old displacements where adhesions have taken place careful packing and gradual restoratives will be required before a hard support can be worn. For this purpose Mr. Harris has made some tampons of fine-carded wool, borated, which, being impervious to water and antiseptic, can be placed *in situ* and act mechanically.

With considerable experience, I am satisfied that much can be done by the proper use of these measures.

J. M. KEATING, M.D.,
Visiting Obstetrician to the Philadelphia Hospital;
Surgeon to Maternity Hospital.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT U.S. ARMY FROM DECEMBER 21, 1884, TO JANUARY 3, 1885.

MCPARLIN, THOS. A., LIEUTENANT-COLONEL AND ASSISTANT MEDICAL PURVEYOR.—Granted leave of absence for three months, on surgeon's certificate of disability. S. O. 301, A. G. O., December 24, 1884.

GIRARD, A. C., CAPTAIN AND ASSISTANT-SURGEON.—Ordered from Department of the Missouri to Department of the East. S. O. 304, A. G. O., December 29, 1884.

JOHNSON, HENRY, CAPTAIN AND MEDICAL STOREKEEPER.—Directed, in addition to his present duties, to perform the duties of Assistant Medical Purveyor in New York City. S. O. 301, A. G. O., December 24, 1884.

WALES, PHILIP G., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Relieved from duty in Department of the Columbia, and ordered to Department of Arizona. S. O. 128, Division of the Pacific, December 17, 1884.

EWING, CHAS. B., FIRST-LIEUTENANT AND ASSISTANT-SURGEON (Fort Stanton, New Mexico).—Granted leave of absence for two months. S. O. 304, A. G. O., December 29, 1884.

NAVAL MEDICAL OFFICERS.

There were no changes in the Medical Corps of the U.S. Navy from December 21, 1884, to January 3, 1885.